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*The*

# OHIO STATE MEDICAL *Journal*

Published By The Ohio State  
Medical Association

## *Featured in This Issue—*

★ Original Scientific Articles:

Select Papers of Particular Interest  
To Physicians in Everyday Practice  
Pages 31 - 55

★ AMA Convention Reports:

Actions Taken at Miami Meeting  
And Parts Played by Ohioans  
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★ Doctor, We Need Your Opinion:

A Readership Survey That Is of  
Vital Importance to *The Journal*  
Pages 95 - 96

*(Turn to Inside Front Cover for Index)*

JANUARY 1965  
VOLUME 41 NUMBER 1

# The OHIO STATE MEDICAL Journal



VOL. 61 JANUARY 1965 NO. 1

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79 E. State Street  
Columbus, Ohio 43215

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## Preventive Medicine Advanced At Ohio State with Grant

The Ohio State University College of Medicine has been awarded a \$267,525 grant from the National Advisory Council on Health Research Facilities of the U. S. Public Health Service.

The grant will be matched by Ohio State to construct a two-story laboratory for research in preventive medicine. It will be located adjacent to Wiseman Hall, 400 W. 12th Ave., which houses College of Medicine research laboratories.

According to Dr. Frederick H. Shillito, professor and acting chairman of the Department of Preventive Medicine, the matching-funds grant has been earmarked by Ohio State as another step forward in broad progress in research in environmental health.

The new research laboratory will stress an interdisciplinary approach, which will take advantage of knowledge, skills and practices from many university departments. This approach will provide a comprehensive platform for research in a variety of fields, such as pollution of the atmosphere or the physiological problems involved with increased barometric pressure.

Dr. Shillito pointed out that research in preventive medicine in vibration, toxicology, aerospace medicine and epidemiology will be furthered in the new laboratory. Research in those fields is already partly housed in Wiseman Hall.

---

## Department of Laboratory Medicine At University of Cincinnati

A new department of laboratory medicine has been set up at the University of Cincinnati College of Medicine with Dr. W. Harold Civin of Honolulu, Hawaii, appointed to direct it.

Dr. Civin will have the title of professor of laboratory medicine, and will also direct the Central Laboratories of the U. C. Medical Center, with headquarters at Cincinnati General Hospital.

Dr. Clifford G. Grulee, Jr., dean of the Medical College, pointed out the new department is designed to take care of the increasingly complex laboratory methods and growth of technology in the area. This has become a special skill within medicine, requiring a full-time staff of specially trained personnel, he said.

---

The Southwestern Ohio Society of Family Physicians held a regular seminar on November 22 in cooperation with the University of Cincinnati College of Medicine. Subject was, "The Problem Child at School and Home." On the program were Dr. Eugene Cash, Dr. Edward L. Pratt, and Dr. Israel M. Dizenhuz, all of Cincinnati, and Dr. W. Hugh Missildine, Columbus.

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Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

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Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

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One tablet (100 mg.) daily with breakfast.

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Tablets of 100 mg. in bottles of 100 and 1000.

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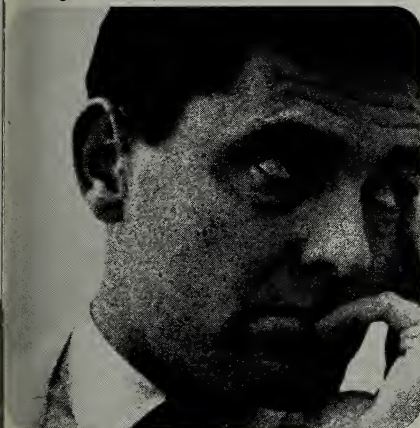
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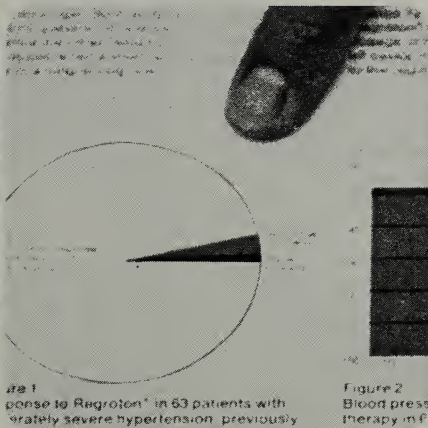
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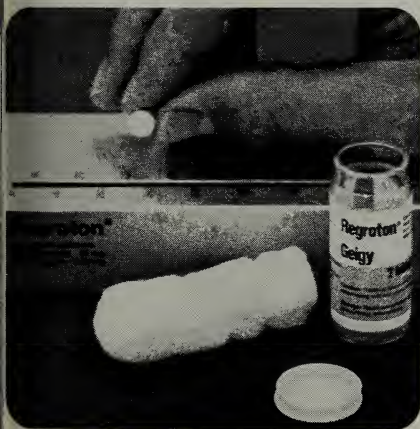
Says who?



Says this 2-year study by Finnerty.



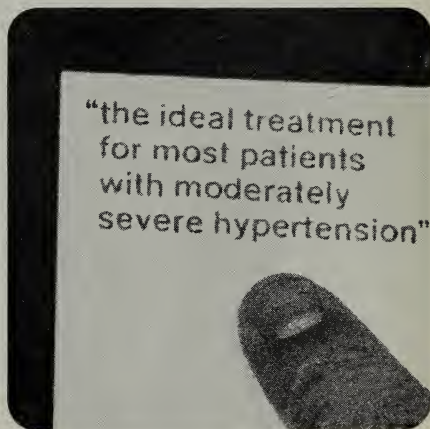
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**Precautions:** Reduce dosage of concomitant anti-hypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or

severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

**Side Effects:** Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

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\*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14-19, 1964.

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## Federal Grants Help Expansion Program at Western Reserve

Grant awards totaling more than \$32 million to 17 of the Nation's schools of medicine, dentistry, and nursing were announced during early fall by the Department of Health, Education and Welfare.

Among the grants were two awards toward the expansion program at Western Reserve University, Cleveland.

One award of \$1,170,204 is for constructing a new building for the Francis Payne Bolton School of Nursing which is expected to cost a total of \$2,054,668. The additional facility will permit the school to accept 73 additional students in both the undergraduate and graduate programs.

Another grant of \$3,229,679 is for replacement and expansion of the dental school. The new facility which will be built at a total cost of \$6,576,123 will permit an immediate increase of 20 entering class students and will provide the potential for a near-doubling of freshman enrollment in the future. Freshman enrollment in dentistry now totals 62.

Applications for the Part I written examination of the American Board of Obstetrics and Gynecology to be given July 2 must be in the hands of the secretary by February 28. The secretary is Clyde L. Randall, M. D., 100 Meadow Road, Buffalo, N. Y. 14216.

## New Members...

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during November. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

### Allen

Herbert J. Beil, Lima  
Joseph G. Deehan, Lima

### Cuyahoga

David L. Barrett, Cleveland  
Tomas I. DeLa Cruz,  
Cleveland  
Godofredo D. Domingo,  
Cleveland  
Abdul F. Naji, Cleveland  
James L. Phillips, Cleveland  
William O. Reid, Cleveland  
Janet Berman Sax, Cleveland  
Richard W. Sherrill, Jr.,  
Cleveland  
Daniel T. Weidenthal,  
Cleveland

### Defiance

David F. Schaefer, Defiance

### Franklin

Hubert T. Goodman Jr.,  
Columbus  
Ralph D. Lach, Columbus  
William B. Mahaffey,  
Columbus

### Hamilton

Gilbert C. Morrison,  
Cincinnati

### Lorain

Richard A. Moore, Elyria

### Lucas

Richard H. Roberts, Sylvania

At a fall meeting in Chicago, the American Otorhinologic Society for Plastic Surgery, Inc., and the American Society of Facial Plastic Surgery, Inc., merged to form the American Academy of Facial Plastic and Reconstructive Surgery, Inc. Dr. Walter H. Maloney, Cleveland, was elected a director-at-large.



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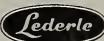


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## New Family Health Guide Available from AMA

The American Medical Association is preparing for publication *Today's Health Guide*, a manual of health information and guidance for the American family.

The manual will be an inclusive compendium of information about health which will be most helpful to the family in making the best and most economical use of the sources of health information, preventive medical services, treatment of illness and adequate meeting of emergencies, an AMA spokesman said.

The 640-page book, in two colors throughout, will include 70 chapters, each dealing with an important aspect of health in the family. It will be illustrated by hundreds of easy-to-understand drawings, including "trans-vision" or full-color "see through" drawings, of the organs and systems of the human body.

More than 200 practicing physicians and specialists, dentists, veterinarians, clergymen, chemists, physicians, nurses, educators, engineers, safety experts, writers and reviewers have a part in assembling the book. There also is wide participation by many members of the full-time staff of the AMA, both as contributors and consultants.

The AMA does not expect to make a profit on the book, and will distribute it in the interest of better

health, the spokesman said. None of those participating in the writing and preparation of the book will be compensated in any way. Regular price will be \$5.95, with an introductory offer of \$4.95. The manual will be distributed from the AMA headquarters, 535 N. Dearborn St., Chicago, by mail order.

### Dayton Physician Honored for Work In Behalf of Handicapped

Dr. Herman J. Bearzy, director of the Physical Medicine and Rehabilitation Department at Miami Valley Hospital in Dayton, received a special citation from the President's Committee on Employment of the Handicapped.

The citation was presented by James A. Devlin, manager of the Ohio Employment Service office in Dayton and general chairman of the Dayton Employ the Physically Handicapped executive committee.

Dr. Bearzy was named for the award for "his exceptional and untiring role in supplying leadership for meeting the adversities of the handicapped."

The U. S. Public Health Service's Neurological and Sensory Disease Service is conducting a research project to determine whether fingerprint analysis may be of value in the detection of neurological abnormalities among newborn infants.

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 245
Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Toledo Health Department 635 N. Erie St.	CH 4-1961—(Day) EV 5-4661—(Night)
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220





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GRACE SPINDLER, R. N.  
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# A Century of Sanitary Fairs and Health Expositions in Ohio

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## PART IV

(Continued from December Issue)

AT the Northern Ohio Tuberculosis Exhibit in Cleveland Sept. 17-26, inc., 1906, speakers for evening lectures included Dr. C. O. Probst of Columbus, the State Health Officer. Samuel Mather and F. F. Prentiss, the President of the Chamber of Commerce, served as chairmen. Another speaker was Max Hayes on "The Working Man and Tuberculosis."

"No tickets of admission will be required," explained Mr. Routzahn. The exhibit was open from 9 a. m. until 10 p. m. on weekdays.

### Excerpts (continued)

EXCERPTS from *The Cleveland Dealer* stories on the Northern Ohio Tuberculosis Exhibit in Cleveland September 17-26, 1906, continue as follows:

*Cleveland Plain Dealer* — Monday, Sept. 17, 1906:  
(Page 4 — Editorial "The Tuberculosis Exhibit"):

"The approaching tuberculosis exhibition under the auspices of the Anti-Tuberculosis League, should mark the beginning of another epoch in the treatment of the dread disease. Cleveland has been singularly free from the encroachments of this malady, when compared with statistics furnished by other cities of the country, but the mortality average of from 10 to 15 per cent in the last few years is an indication of the hold it has here.

"The combined efforts of the sociological, charitable and religious associations, directed through the Anti-Tuberculosis League, have greatly alleviated the conditions. The city, through its municipal sanitarium and the newly opened tent colony, has contributed in no small measure to this success . . ."

On the same day there is a story on page 10, titled "Children To Be Taught Health."

"Pupils from the schools will visit Anti-Tuberculosis exhibits today."

"Great results have been obtained this way" says Director.

The students arrived at 9, 10 and 11 and were from the 7th and 8th grades. There were stereopticon lectures and demonstrations every hour through-

out the day. The article was illustrated by three photos titled

- a. "How the battle is waged against the great white plague"
- b. "Tray Room in Consumption Hospital"
- c. "A Canvas Shack in Winter — A Veranda at Saranac Lake, New York"

Below the three photos there is a story on

"Slight return of old illness. Rockefeller spends his Sunday quietly at Forest Hills Estate. Little grandson comes from Chicago for a visit of a month."

Another story reads,

"Surgeon's Knife Changes Nature."

"Patient operated on for bad temper is no longer morose."

"Cheery disposition takes the place of gloom — full success hoped."

*Cleveland Plain Dealer* — September 19:

"From 20 to 40 is danger period."

"Consumption works its ravages in most useful part of people's life."

"Tuberculosis experts tell how disease can be prevented and cured."

There are two illustrations, one showing the arrangements of exhibits, including tents for open air treatment.

Next to the story on the tuberculosis exhibits and about the same length is a story "A truly ideal wife — her husband's best help" which is a testimonial by Mrs. Bessie Ainsle giving testimony to Mrs. Lydia S. Pinkham's vegetable compound."

There are other testimonials on quack medicine.

*Cleveland Plain Dealer* — Sunday, April 23 (Part 2):

"Will give new life to crusade."

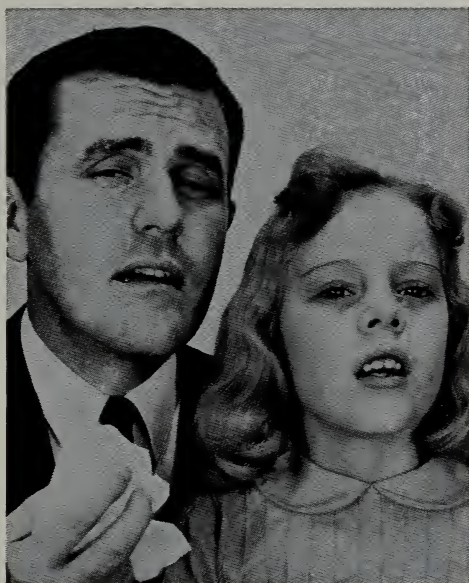
"Campaign on tuberculosis to wax hotter than ever as exhibit."

"Estimated that 30,000 people have visited the Central YMCA."

The article reviews the amount of \$70,000 which has been expended in the fight to date. \$22,695

\*Read at the 1964 Annual Meeting of the Ohio Academy of Medical History, April 18, 1964, Granville, Ohio.

\*Dr. Gebhard, Cleveland, is Director of the Cleveland Health Museum, 8911 Euclid Avenue, Cleveland, Ohio.



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*Flexible liquid DOSAGE: Adults — 2 tsp. 3 or 4 times daily. Children 6-12 yr. — 1 tsp. 3 or 4 times daily; 4-6 yr. — ¼ to ½ tsp. 2 or 3 times daily; 1-4 yr. — 18 to 36 drops 2 or 3 times daily; 1-12 mo. — 6 to 18 drops 2 or 3 times daily.*

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Phenylpropanolamine Hydrochloride	75 mg.
Methapyrilene Fumarate	25 mg.
Pyrilamine Maleate	25 mg.
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Three antihistamines are combined for supra-additive effectiveness (greater than the expected  $1+1+1=3$ ) to reduce mucosal edema, itching of the eyes, sneezing, rhinorrhea.

*diabetes, heart or thyroid disease. Antihistamines occasionally produce drowsiness; patients should be warned against operating autos or machinery if this occurs.*

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went to several hospitals, other amounts to the Visiting Nurse Association, the Associated Charities, the Warrensville City Sanatorium and towards the establishment of a laboratory for sputum examinations. It also mentions that "the congested districts and the localities in which the most fatalities have occurred are shown to be in that territory lying north of Superior Avenue from the river to 30th Street and on the central West Side."

There is a second story on the same page titled "Ask public to attend exhibit."

"Health Officer, Martin Friedrich, M.D., declares it a duty to learn about plague. Says more lives are forfeited to consumption than to war.

"In his lecture at the YMCA, Dr. Martin Friedrich said that eight million of the 80 million people now living in the United States will die from tuberculosis. 50,000 Clevelanders are doomed to the same fate.

"Cleveland loses at least one million yearly through the ravages of the white plague."

*Cleveland Plain Dealer* — September 26:

The story on the exhibits entitled "Father's cough alarms urchins."

"Two young visitors at exhibit learn tuberculosis symptoms with dread. They fear parent is affected and are eager to learn how to help him."

Above this story is an illustrated ad of the Gund Brewing Company reading,

"Good beer is health giving, refreshing and delightfully palatable. It has done more to promote real temperance than all other agencies combined. Ask for it downtown — have a case sent home."

\* \* \*

#### Health Exhibition on Wheels

An "Ohio Society for the Prevention of Tuberculosis" was organized on November 14, 1901, in Columbus, but up to 1909, the Society had a "fitful existence as an organization" according to Robert G. Paterson. It was the Sixth International Congress on Tuberculosis, held in Washington, D. C. in the fall of 1908, where for three weeks representatives of 32 countries met in the stately Assembly Hall of the National Museum, newly built and still unoccupied, which gave real impetus to the campaign against the "White Plague." President Theodore Roosevelt, chairman of the Congress, made a stirring speech. The exhibits that filled the spacious display rooms comprised the greatest TB show on Earth. The Transactions fill eight volumes.<sup>18</sup>

During World War I, something new came up in public health education, the educational motion picture. It was very quickly combined with another novelty which gained increasing public acceptance — the automobile. The new type of traveling exhibit combined both in the form of a "Healthmobile." Harry E. Kleinschmidt, M.D., as Director of the Bureau of Health Education, toured many countries, looking on himself as the 20th Century version of Johnny Appleseed of Health Education. (He was the 1949 winner of the Prentiss Award, given by the Cleveland Health Museum; E. G. Routzahn was the very first recipient, together with his wife Mary, in 1944.)

In Columbus, Robert G. Paterson arranged for the first exhibit on Tuberculosis at the Ohio State Fair, on September 1, 1913.

"The first exhibit on tuberculosis, sponsored by the State Board of Health in Ohio, was shown on September 1, 1913, at the Ohio State Fair. The exhibit covered the whole field of public health work. I have photographs of this exhibit which was then used as a traveling exhibit by the Division of Tuberculosis and Public Health Education of the Ohio Department of Health. Dr. Paterson was chief of this division from 1913 to 1916 and helped organize the exhibit and carted it around the State by interurban express car." (according to John A. Louis.)

#### After World War I

It takes wars and explosive epidemics to make people aware of the dangers which threaten the health and welfare of a nation. So did World War I and especially the influenza epidemics of 1917-1918. There was a resurgence of child welfare activities in the early 1920's. The American Red Cross brought forward the idea of Health Centers and promoted health education in schools. There was especially the newly founded American Child Health Association, which pushed forward better health services for children. The nation's attention for four years was on Mansfield (Ohio) and Richland County, where a child health demonstration was carried on. Richard A. Bolt and John Hart Davis, M.D., later working in Cleveland, were the leaders in the demonstration project. A huge parade of 3500 blue ribbon children was one of the climaxes of that demonstration.

*(To Be Concluded in February Issue)*

#### Reference

18. Kleinschmidt, H. E.: The Changing Years. National Tuberculosis Assn., 1954, p. 11.

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## Thymoma, Myasthenia Gravis, And Aplastic Anemia

### Report of a Case

VICTOR R. HINRICHS, M.D., and THOMAS D. STEVENSON, M.D.

THYMOMA is an uncommon mediastinal tumor which produces symptoms and signs primarily by mechanical compression of other mediastinal structures, and distant metastases are rare. In certain instances, however, systemic manifestations may be present, and the association of myasthenia gravis with thymoma is well known. A thymoma has been reported in 28 per cent of patients with myasthenia gravis.<sup>1</sup> Other conditions which have been described in association with thymoma include an anemia due to selective erythroid hypoplasia of the bone marrow or pancytopenia with marrow aplasia, Cushing's syndrome, agammaglobulinemia, and dermatomyositis.<sup>2,3</sup> The pathogenesis of these varied systemic manifestations and their relationship to the thymic tumor are unknown. Current evidence indicates a primary role of the thymus in the immune mechanism, and it would seem appropriate to consider the systemic manifestations associated with thymoma as examples of an autoimmune disorder.<sup>4</sup> Some evidence for an abnormality of the immune mechanism has been found in myasthenia gravis, and there are some suggestive findings not inconsistent with an abnormal immune mechanism in the anemia associated with thymoma.<sup>5</sup>

Anemia associated with thymoma is rare. It is

#### *The Authors*

- Dr. Hinrichs, Columbus, is Resident in Pathology, Riverside Methodist Hospital.
- Dr. Stevenson, Columbus, is Assistant Professor of Pathology, The Ohio State University College of Medicine.

most often due to hypoplasia of the erythroid elements of the bone marrow. In 1962, Dreyfus et al. reviewed the literature and found 47 reported cases of anemia associated with thymoma and presented an analysis of 43 cases including two of their own.<sup>6</sup> Although anemia was the only hematologic abnormality found in the majority, an associated leukopenia or thrombocytopenia was described in 13 of the reported cases. We have had the opportunity to study a patient with myasthenia gravis who subsequently developed a thymoma and pancytopenia with severe marrow hypoplasia. The rarity of this syndrome and some interesting aspects of the pathologic findings prompted the present report.

#### *Case Report*

This 47 year old white man with known myasthenia gravis was admitted to the hospital complaining of weakness and bleeding from his gums. He had been in good



health until five years prior to admission when he noted severe muscle weakness, ptosis of the eyelids, and diplopia. A diagnosis of myasthenia gravis was made, and he was maintained relatively symptom free by using ambenonium 20 mg. orally every four hours. On two occasions in this five year period, he had "crises" which were apparently due to the excessive use of ambenonium. In the week preceding hospital admission, he had noted some increasing weakness, and two days prior to admission, he had first noted rather profuse, persistent bleeding from his gums.

Past history and systemic review were noncontributory.

Physical examination revealed an acutely ill white man.

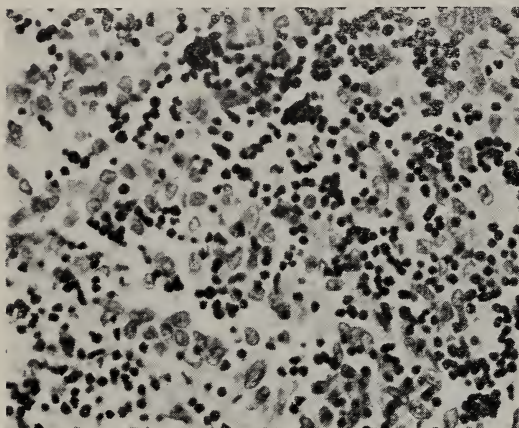


FIG. 1. Thymic tumor composed of lymphocytes and epithelial cells. H & E Stain X 250.

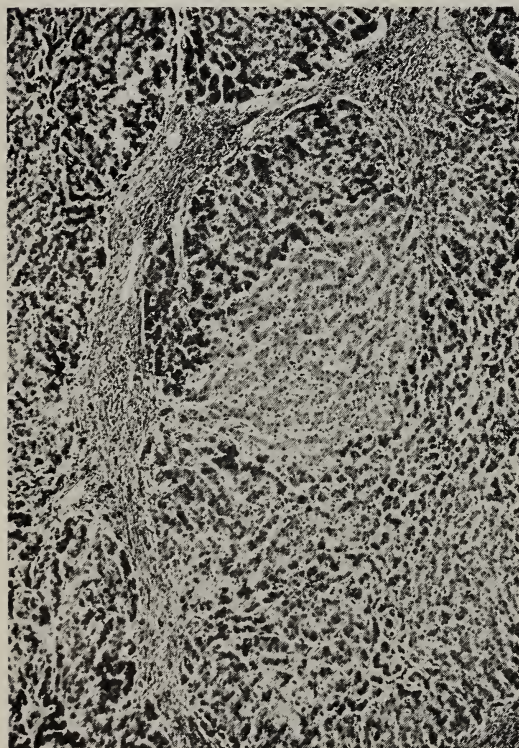


FIG. 2. LIVER: The hepatic cells in the periphery of the lobule are dark in color due to the presence of iron and there is periportal fibrous tissue proliferation. H & E Stain X 50.

Temperature was 102.6°F.; pulse rate 124 per minute; respiratory rate 22 per minute; blood pressure 120/70.

Significant features were as follows: Numerous petechiae were noted over the trunk and extremities. The gums were friable, and blood was oozing continually from the gingival margins. Ptosis of the eyelids was present bilaterally. Fine rales were heard over both lung bases posteriorly. There was generalized muscle weakness, and apokamnosis was present in major muscle groups. The liver and spleen were not palpated. The remainder of the physical examination was not remarkable.

**Laboratory Data:** Hematocrit 17 per cent, hemoglobin 7.0 Gm/100 ml., red blood cell count 1.84 mm<sup>3</sup>, white blood cell count 2,630 mm<sup>3</sup>. Polymorphonuclear leukocytes 4 per cent, lymphocytes 94 per cent, monocytes 2 per cent. Platelets 30,000 mm<sup>3</sup>, reticulocytes 0.0 per cent. Serum iron 222 mcg/100 ml. Iron binding capacity 251 mcg/100 ml. Blood culture revealed no growth after 48 hours. A bone marrow specimen was aspirated with difficulty from a spinous process. No fragments of marrow were seen. Microscopically, the specimen consisted of a scattering of lym-

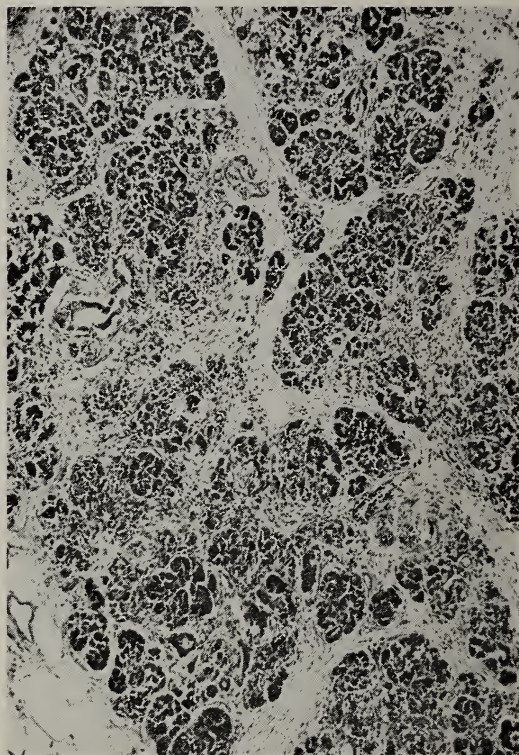


FIG. 3. PANCREAS: There is a marked increase in interstitial connective tissue. The dark staining acinar cells contained hemosiderin. H & E Stain X 50.

phocytes and a few normal marrow elements. Urinalysis revealed no significant abnormalities. The serum uric acid was 2.8 mg./100 ml. The total protein was 6.6 Gm/100 ml., albumin 3.6 and globulin 3.0 Gm. No abnormal proteins were demonstrable by electrophoresis and the gamma globulin concentration was 1.26 Gm/100 ml. Chest x-ray revealed blunting of the right costophrenic angle and a mass in the left hilar region, which displaced the trachea to the right.

**Hospital Course:** The initial clinical diagnosis was myasthenia gravis complicated by pneumonia. Subsequent hematologic studies were consistent with aplastic anemia, and the chest x-ray was consistent with a thymoma. The patient was given antibiotics but remained febrile, and muscular weakness became more pronounced. He was treated by



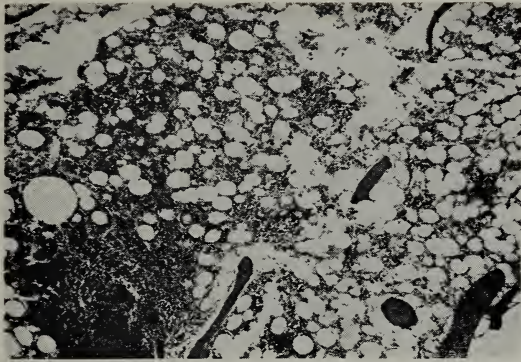


FIG. 4. BONE MARROW: Section of marrow showing general hypocellularity. Multiple sections of bone marrow were taken from various sites and this field represents one of the most cellular areas seen. The dense cellular area is composed almost entirely of lymphocytes. H & E Stain X 50.

transfusion with 2 units (1000 ml.) of whole blood. On the second hospital day, it was necessary to place the patient in a respirator because of respiratory difficulty. Despite supportive measures, he became progressively weaker, lapsed into coma and died four days after admission to the hospital. It was the final clinical impression that the patient had myasthenia gravis and aplastic anemia associated with thymoma and that death was due to sepsis.

**Postmortem Findings:** Petechiae were scattered over the skin, the epicardium, the endocardium, the mucosa of the large and small bowel, and throughout the cerebral hemispheres. There was a large amount of hemorrhage about the brain stem and within the cerebellum and pons.

A 10 by 10 by 7 cm. yellow gray mass was present in the anterior mediastinum. The mass did not invade the lungs, pericardium or great vessels.

The liver weighed 2200 Gm. The pancreas weighed 90 Gm., was reddish brown, and very firm in consistency. The spleen weighed 280 Gm. The peripancreatic lymph nodes were enlarged and dark red.

On microscopic examination the thymoma was divided into segments by broad fibrous bands (Fig. 1). These segments of the tumor were composed of lymphocytes and epithelial cells. The lymphocytes were mature small cells and were predominant in some areas while in other areas the epithelial cells were predominant. The epithelial cells had a clear cytoplasm with vesicular nuclei and were arranged in sheets and bands which formed sinusoids in some areas.

Histologic study of the liver revealed a periportal fibrous tissue reaction and a large amount of iron-positive pigment was present in the hepatic cells (Fig. 2). Acinar and ductal cells of the pancreas also contained pigment deposits and fibrous tissue proliferation was present (Fig. 3).

Iron-positive pigment was not present in the spleen. The sinusoidal cells of the peripancreatic lymph nodes contained hemosiderin. Iron pigment was also present in the collecting tubule cells of the kidneys, the acinar cells of the thyroid, the zona glomerulosa of the adrenals, the pituitary and gastric glands.

The bone marrow was hypocellular and composed primarily of fat. Erythroid elements were markedly reduced and only a small number of myeloid elements were present (Fig. 4).

The final anatomical diagnoses were: (1) Subdural, subarachnoid and intracerebral hemorrhage, (2) Thymoma, (3) Hemochromatosis with cirrhosis and pancreatic fibrosis, (4) Myasthenia Gravis, Clinical, (5) Aplastic Anemia.

## DISCUSSION

### 1. Clinical Features

The clinical manifestations of the anemia associated with thymoma have been reviewed in detail by Dreyfus.<sup>6</sup> This syndrome has been described only

in adults and the principal incidence is in the 50 to 60 age group. It has been reported slightly more often in women than in men, but there is no racial predilection. The principal symptoms are due to anemia which is insidious in onset and rarely of acute onset as the history suggested in our patient. Occasionally, cutaneous and respiratory infections occur in patients with an associated leukopenia. There are no characteristic physical findings except those due to anemia. Lymphadenopathy and enlargement of the spleen and liver have been described but are very rare.

The principal hematologic abnormality is anemia which is usually moderately severe (hemoglobin 5 to 10 Gm per 100 ml). There are no characteristic morphologic changes in the erythrocytes, i.e. the anemia is normocytic and normochromic. Reticulocytes are markedly decreased, and in the majority of cases bone marrow examination reveals hypoplasia of the erythroid elements of the marrow with normal megakaryocytes and granulopoiesis. The anemia may be present before the thymoma is detected, but it usually follows the appearance of the thymic tumor. In 14 cases including our own, a pancytopenia due to hypoplasia of all marrow elements have been found.<sup>6</sup> It is not possible to determine whether the pathogenesis of the pan-marrow hypoplasia differs from selective erythroid hypoplasia or if the latter is but the initial manifestation of a process which ultimately results in hypoplasia of all marrow elements. In four of the reported cases of anemia associated with thymoma, pancytopenia has developed after the onset of the anemia. It should be emphasized that anemia is the most important and consistent hematologic abnormality and leukopenia and/or thrombopenia without anemia has never been described. In one case, however, thymectomy alleviated the anemia but an associated thrombopenia persisted. There are eight cases including our own in which the triad of anemia, thymoma, and myasthenia gravis have been described, and ours is the third case with pancytopenia.

### 2. Pathogenesis

The pathogenesis of the anemia and its relationship to the thymoma are obscure, and there are several possible mechanisms to be considered. The rarity of anemia due to specific erythroid hypoplasia and the fact that thymoma is an uncommon tumor makes the fortuitous association of anemia with thymoma unlikely. There is some evidence for a direct role of the thymus in the causation of the anemia, since, in 10 of the reported cases, thymectomy has resulted in complete or partial alleviation of the anemia. Attempts to demonstrate a humoral factor of thymic origin with an effect on hematopoiesis in animals or men have been unsuccessful, however, and there is no evidence that a humoral factor is involved in the pathogenesis of the anemia.

Dreyfus et al. have proposed a common enzymatic

defect in the tissues involved e. g. muscle, red cell, etc., as a possible mechanism for the production of this syndrome but there is no evidence to support this concept.

Drug induced marrow aplasia warrants consideration since our patient had been taking cholinergic drugs for five years to control the symptoms of myasthenia gravis. This seems most unlikely as an etiologic factor since aplastic anemia has not been reported following the use of these drugs, and no other drugs capable of suppressing the marrow had been used by the patient nor was there a history of exposure to solvents or other chemical agents.

The role of autoimmunity warrants serious consideration in the production of this syndrome since the thymus has a primary role in the immune mechanism as a source of lymphocytes which produce antibody.<sup>4</sup> Antibodies reacting with skeletal muscle, thymus, and thyroid have been described in patients with myasthenia gravis.<sup>5</sup> There is also evidence of an immunologic abnormality in the anemia-thymoma syndrome, since, in five patients including our own, a positive Coombs' test has been demonstrated.<sup>8, 9, 10, 11</sup> A positive Coombs' test is a rare finding in idiopathic aplastic anemia and when present is usually attributed to red cell sensitization subsequent to blood transfusions. This was not the mechanism in our case since the patient had not received transfusions previously. The occasional finding of a positive LE cell test and agammaglobulinemia in this syndrome are also suggestive of an abnormality of the immune mechanism.<sup>9, 10</sup> The significance of these immunologic abnormalities in the pathogenesis of the anemia and marrow hypoplasia is unknown. An immune abnormality is not considered a significant factor in the production of idiopathic aplastic anemia but marrow aplasia may occur as a complication of chronic hemolytic anemia and has been described in acquired autoimmune hemolytic anemia.<sup>12</sup> If the anemia of thymoma is fundamentally an autoimmune hemolytic anemia complicated by marrow aplasia as has been postulated, it should be possible to demonstrate a decrease in red cell survival in addition to diminished erythropoiesis in these patients. With rare exceptions, red cell survival has been normal or only slightly decreased in patients with the anemia-thymoma syndrome, which excludes hemolysis as a primary factor in the anemia.<sup>6, 13, 14, 15, 7, 11</sup> It is of interest that the red cell survival has been normal when the Coombs' test was positive.<sup>9</sup>

It has been proposed that the major site of antigen-antibody reaction in this syndrome is the nucleated erythroid elements of the marrow, but it would be remarkable indeed if mature red cells were unaffected and capable of normal survival under these circumstances. It has also been suggested that antibody might react with erythropoietin, but erythropoietin titers are usually increased in aplastic anemia, and this would not explain the pancytopenia and panmar-

row hypoplasia which has been observed.<sup>16</sup> The erythropoietin titer was increased in one patient with this syndrome in whom this factor was measured.<sup>9</sup> Although the autoimmune hypothesis is attractive and currently popular, the evidence for this mechanism as a cause of the varied manifestations of this syndrome, particularly the hematologic, is far from convincing. Further study of this rare entity is necessary, and it would be of value to do Coombs' tests and erythrokinetic studies on patients with myasthenia gravis and a thymoma. Of interest in this regard is the recent report of a cure of an autoimmune hemolytic anemia by thymectomy.<sup>17</sup>

Of the various factors considered in the pathogenesis of the anemia associated with thymoma, however, the autoimmune hypothesis seems most likely on the basis of the currently available evidence. The nature of the abnormal immune mechanism, the cell, or cellular constituents involved in the antigen-antibody reaction remain to be demonstrated. The discovery of a genetically determined autoimmune hemolytic anemia in mice may provide the experimental model necessary to elucidate the relationship between the thymus and hematopoiesis.<sup>18</sup>

### 3. Pathology

The pathology of the thymic tumor is not distinctive in this syndrome. The tumor is composed of two basic cellular elements, the epithelial cell and the lymphocyte; when the epithelial cell predominates the tumor is classified as either a spindle cell or epithelial cell thymoma and lymphoid when lymphocytes are the principal cellular element. Predominance of both cellular types have been described in association with anemia and marrow hypoplasia.

The marked tissue hemosiderosis, which in the liver was associated with periportal fibrosis consistent with hemochromatosis, was of particular interest in the case described herein. Hemosiderosis of varying degrees has been found in 14 of the previously reported cases but in only one was there evidence of portal cirrhosis as in the present case.<sup>19</sup> The hemosiderosis has most often been explained on the basis of frequent blood transfusions. In some cases, however, it has been noted that the amount of tissue iron was excessive for the number of transfusions given and in our case, only two blood transfusions were given and these in the last four days of life.

Secondary hemosiderosis may also occur as a consequence of prolonged oral iron administration in the presence of anemia. The excessive iron absorption in these instances is usually associated with a hypercellular rather than a hypocellular marrow. To the best of our knowledge, our patient had never taken any oral iron preparation and the source of the excess iron in this patient cannot be explained by any of the usual mechanisms. The fact that hemosiderosis is a not uncommon finding in this syndrome and not always explained by transfusions may indicate an abnormality of iron metabolism in



addition to the other abnormalities. Ferrokinetic studies, when performed, have been consistent with diminished erythropoiesis but studies of iron absorption have not been reported and would be of interest.

### Summary

A case of pancytopenia associated with thymoma and myasthenia gravis is presented. The current concepts of the pathogenesis of the anemia occurring in this syndrome are reviewed. Hemochromatosis of the liver, which was found on postmortem examination, was not explained by any of the usual causes of exogenous iron overload.

**Acknowledgment:** The authors are indebted to Dr. Richard C. Brandes for permission to publish this case.

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**T**HOMAS LINACRE and his little band of devoted medical colleagues initiated a revolution in the organization of the profession and sounded a call for higher standards in training and ethics that has constituted the grandeur of the Royal College of Physicians throughout its long history. The fact that he advocated the out-of-date scholastic approach to medicine by his devotion to Galen and the ancient writers, and that he ignored the signals of a new science which had already appeared above the horizon, has its warning for those of us who engage our lives in the detection and prevention of the ravages of disease.

We, too, are faced by the tremendous upsurge of science in general and of scientific medicine in particular. The challenge is, I believe, a much more serious one in medicine than in other disciplines, for it is all too easy for the doctor to take refuge in the time-honoured beliefs of the past and rest content with delegating, often with scarcely concealed contempt and patronage, the duty of investigation to a little band of dedicated workers.

No one who has come through an illness, will decry the God-given qualities that warm the personality of the born clinician and make him an ever-present help in times of trouble. But these gifts are still menaced by pretence and humbug which is not confined to the ignorant and indolent but threatens the seats of the mighty and successful.

We who spend much of our lives in training the oncoming member of our profession must be especially alert to challenge and combat the shoddy and the sham, the facile explanations, the dead-hand of plausible empiricism. Like Linacre, we are standing at the portal of a dazzling, unbounded world of medical science, entry to which calls for courage, imagination, and the highest qualities that bless the human spirit. May we not be found wanting when the opportunity of playing our part comes our way. — Sir Roy Cameron, M. B., D. Sc., LL. D., London, England: *British Medical Journal*, 2:589-594, September 5, 1964.

# Weight Lifting *versus* Isometrics

## A Comparative Study in a Small Group of High School Boys

MARVIN McCLELLAN, M.D., and JAMES HEINOLD, B.Ed.

IN THE last few years increasing attention has been focused on physical fitness and muscular strength. The method whereby greater muscle mass and strength is achieved depends upon the overload principle; that is, the muscle is overloaded, placed under stress, and because of excessive use, it hypertrophies. There has been considerable discussion as to the proper manner of exercise to achieve this result. One group contends that isotonic contractions, in which the muscle is shortened and exercised under a load so that work and movement are produced, is the better method. Another group contends that isometric contractions, in which the muscle contracts but there is no joint motion or movement in the direction of the contraction, is better.

Like most schools we were caught up in the weight training program and were convinced of the value received. Then came isometrics and all the claims for this revival of an old form of exercise. We knew isometrics cost less, required less space, and took less time, but could it do the job? Our team physician suggested we find out. As a result, this 15 week study was initiated with the following objectives: (1) to determine which training method produces more muscle mass; (2) to determine which training method produces greater improvement in muscular performance; and (3) to compare lactic acid content in the blood before and after training with both systems.

From the athletic director's standpoint, it is much easier to watch the progress and exercise of a student who is weight lifting than one doing isometric exercises. The reason is that with weight lifting the athlete can be seen performing a certain amount of actual exercise at a given weight in a given time. With isometric exercises, the athlete may or may not be producing actual muscular contractions, at least no one but he can determine this.

From the student's or athlete's standpoint, exercise done with weights necessitates assembling and disassembling a considerable amount of equipment. However, there is the gratification of performing a definite function against a definite resistance. In the case of isometric exercises on the other hand, the equipment is meager or nonexistent, so very little time is expended in getting ready for or finishing the exercise

### *The Authors*

● Dr. McClellan, Cincinnati, is Instructor in Pediatrics, University of Cincinnati College of Medicine; chairman of the Athletic Medical Advisory Committee of the Cincinnati Academy of Medicine, and a member of the Ohio State Medical Association Committee on the Medical Aspects of Sports.

● Mr. Heinold, Cincinnati, is Director of Physical Education, Western Hills High School of Cincinnati.

period. There is no time consumed in changing equipment as with weights and, therefore, the exercises can be performed in a much shorter time. However, pressing against an immovable object may result in very little gratification for having performed the task. Consequently, there is some psychological difference in the approach to the two exercise methods.

From the standpoint of the athletic supervisor, it would certainly be easy for the athletes to "fake out" exercises with the isometric method. However, by measuring blood lactate levels, we can prove that an athlete has done his isometric exercises sufficiently. In 1941, Robinson and Harmon<sup>1</sup> reported that in submaximal running exercises the blood lactate level declined significantly with training. In 1936, Bang<sup>2</sup> and others established that there was a maximal rise in the blood lactate proportionate to the work done and that, in general, well trained athletes showed a smaller rise in the blood lactate level after exercising than poorly trained athletes did.

As a consequence of these conclusions, if a group of athletes had blood lactate levels taken in a resting state and then exercised, there would be a rise in the blood lactate to a higher level. The height of this rise should be less in a well trained athlete or after a training program than it was in the beginning of such a program. Therefore, by using this lactate rise, one could determine whether a given athlete had really trained during the training program or whether he had merely gone through the motions. With this in mind an experiment was set up to determine the varying values of weight lifting *versus*

<sup>1</sup>Submitted July 15, 1964.



isometrics in the production of muscle strength and mass in a group of boys in High School.

Method

For the purposes of the exercise program, we set up two groups of boys, six for isometrics and six for weight lifting. Within each group of six, three boys were previously trained and three boys had no previous athletic training. These boys were matched, one in each group for grades 10, 11, and 12. No attempt was made to match the boys any further as to build, height, weight, or stage of physical development. No attempt was made to control the diet or extracurricular activities outside the weight training program of these boys. In this sense, the program was not strictly a controlled study. However, we think that this matching was as near as one could go to a controlled study under the circumstances of ordinary daily living.

It was necessary to obtain written permission from the board of education and the parents before we could proceed (Fig. 1).

- AN EXPERIMENTAL STUDY is in the process of being set up to determine the relative value of isometric exercises and weight lifting for the building of muscle mass and strength.
- The experiment will be performed under the direction of Mr. James Heinold, the Athletic Director of Western Hills High School, and Doctor Marvin McClellan, an Athletic Department Adviser. There will be three periods of exercise per week for about 15 weeks; probably in the morning before school begins. At the beginning of the process a small sample of blood will be taken to determine the blood lactate level. A second sample will be taken after the first or second exercise period and a third at the completion of the whole experiment. The boys participating will be furnished the equipment to use and there will be no charge for the blood determinations.
- In addition each boy participating will make a choice of any item up to \$20.00 in value from the McGregor Sports catalog; if he participates fully and attends all the exercise sessions. Even one missed period without written excuse from his physician will disqualify him.
- As his legal guardian or parent I consent to the participation of ..... in this study.

.....  
Parent or guardian

FIG. 1. Letter of consent for participation.

Our procedure may be summarized as follows:

- A. Selection of subjects to perform
1. Random selection within three grades.

2. Athletes and nonathletes—half each.
- B. Determine the lactic acid content of blood
1. At rest, after fasting, and before training.

2. After the first exercise period.

3. After the last exercise period, 15 weeks later.
- C. Measurement of various muscle groups
1. Before the training program.

2. After the training program.

D. Tests to determine physical strength

1. Before training.
2. After training.

E. Comparable exercises to be performed by each group three times per week for 15 weeks

1. Isometrics subjects are to perform each exercise in three joint positions, about 45°, 90° and 135°, where applicable, for 10 counts in each position.
2. Weight lifters are to use the maximum weight for eight repetitions; when 12 repetitions can be performed, increase the weights.

In order to verify the fact that the boys on weights and isometrics had exercised as they were instructed

TABLE 1. Exercises Performed by Participants

EXERCISE	WEIGHTS			ISOMETRICS	
	Average Weight		Repeats	Hold & Count	Repeats
	Start	Finish			
Wrist Curl	54 lbs	79 lbs	10	10	3
Curl	50	73	10	10	3
Arm Raise Behind Neck	48.5	69	10	10	3
Reverse Curl	43	65	10	10	3
Straight Arm Forward Raise	35	41	10	10	3
Rowing	56	97	10	10	3
Back Arch	46.5	66	10	10	3
Bench Press	66	98	10	10	3
Half Squat	83	147	10	20	1
Toe Rise	86	137	25	25	1
Wrestler's Bridge	33	46.5	10	10	2
Sit-ups	18.5	31	10	10	3
Press	68	82	10	10	3

TABLE 2. Blood Lactic Acid Values in Weight Lifters (W) and Isometric Exercisers (I)

Subject	At Rest — Fasting	After Exercises	
		First	Last
W-1	87.5 mg/100 ml	111 mg/100 ml	42 mg/100 ml
W-2	67.5	94	39.5
W-3	39	101	47
W-4	35.5	125	29
W-5	Incomplete	....	....
W-6	Incomplete	....	....
I-1	49.5 mg/100 ml	81 mg/100 ml	11.5 mg/100 ml
I-2	47	114	31.5
I-3	41	126	9.5
I-4	36.5	110	26.5
I-5	24	84	16
I-6	24	83	26.5
I-7	20.5	121	23.5
Av. W	57.37 mg/100 ml	107.75 mg/100 ml	39.38 mg/100 ml
Av. I	34.64 mg/100 ml	102.71 mg/100 ml	20.71 mg/100 ml
Compare with rest W	up 50.38 mg/100 ml		down 17.99 mg/100 ml
Compare with rest I	up 68.07 mg/100 ml		down 13.93 mg/100 ml

to do, blood lactate levels were taken at the beginning of the exercise period. After the second exercise session, when the boys were properly fatigued by their exercise, a second blood lactate level was taken. Then, at the end of the total program of exercise, 15 weeks later, the boys went through their final exercise period and blood lactate levels were taken again.

To begin the program, the "vampire," as the doctor was soon called, took the samples before the boys had eaten and before any exercise. The program was not to train athletes but to work the measurable muscles and improve the selected calisthenic exer-

gram, while the boys performing isometrics needed only 20 minutes to complete the routine. The exercises performed by each group are listed in Table 1.

## Results

Table 2 illustrates that in all instances, the blood lactate rose after the first exercise period. At the end of the 15 week exercise program, the blood lactate rose again but less than the first postexercise level. In all instances, the second postexercise lactate value was lower than the first. This indicated to us that all of the boys on both isometrics and weight lifting had performed their exercises well during the

TABLE 3. *Muscle Measurements of Weight Lifters before and after Exercise Program*

	W-1	W-2	W-3	W-4	W-5	W-6	Av. Chg.
Age	17	17	17	16	16		
Height	69¾"	69½"	68"	69½"	66"	72"	
Weight	160	138	160	125	162	189	
	162	138	163	130	175	189	+ 3.83
<i>Left</i>							
Calf	14	13¼	14¾	12½	15½	15¼	
	14	13¾	14¼	12½	16¼	15½	+ .25
Thigh	22	20½	22	19¾	23½	24	
	22	20½	22¼	19¾	24¾	24¼	+ .29
Fore-Arm	10½	10	11	9	11	11¼	
	10¾	10	11	9¼	11¾	11¼	+ .21
Biceps	11¾	10¼	11¼	9¾	11½	12½	
	12	10¼	11¾	10¼	12¾	13	+ .58
<i>Right</i>							
Calf	13¾	13½	14¼	12½	15½	15¼	
	14	14	14¼	12¾	16½	15½	+ .46
Thigh	21¾	20¼	21¾	19¾	23¾	24	
	22	20¾	22	19¾	24¾	24½	+ .42
Fore-Arm	10½	10	11	9¼	12	11½	
	11	10¼	11	9½	12¾	11¾	+ .21
Biceps	12	10¼	11	9½	11¾	12¾	
	12¼	10¼	11¾	10¼	12¾	13	+ .42
Waist	31½	28	32	27½	32½	35	
	30½	28¼	32	27	33¾	35	0
Neck	15	13½	15	13½	14½	15¼	
	15	13¾	15	13¾	15	15½	+ .21
<i>Chest</i>							
Normal	36	33¼	37	33	32½	39½	
	36	33½	37	33	39½	39½	+ 1.21
Expand	38	35½	38¼	34¼	35¼	41¼	
	39	36¼	39	36	41½	42	+ 2

cises. The weight lifters were to start with a weight that could be moved through eight repetitions and no more. When 12 repetitions were possible, the weight was increased until only eight repetitions were possible again. The boys on isometrics held the muscle contractions for 10 counts in each of three angles of movement of the joint, about 135°, 90° and 45° angles. This amounted to about four seconds in each position or a total of 12 seconds. The boys worked three mornings a week and 30 minutes per day at the unseemly hour of 7:15 a. m. The weight lifters required about 45 minutes for the pro-

15 weeks. It is significant to note in 9 of the 11 subjects that the *postexercise* lactic acid levels were lower after the training period than they were *at rest* in the beginning of the experiment. In comparing the two methods, we found that after exercise the blood lactic acid levels in the weight lifters were 4.06 per cent lower than those of the isometrically trained boys.

To determine growth in muscle mass, each boy was measured before the first exercise period and again at the completion of the fifteen week program. Tables 3, 4 and 5 give a comparison of muscle mass



TABLE 4. *Muscle Measurements of Isometric Exercisers Before and After Exercise Program*

	I-1	I-2	I-3	I-4	I-5	I-6	I-7	Avg. Chg.
Age	16	17	18	15	16	15	15	
Height	73½"	66½"	70"	71"	72"	59"	69"	
Weight	150	141	132	130	147	118	145	
	150	143	136	138	154	117	153	+ 4
<i>Left</i>								
Calf	14	13¾	13	12¼	14	11½	14	
	14¼	14¼	13¼	12¾	14¼	15	14¼	+ .89
Thigh	20½	20	19¼	19	20	21¾	20¾	
	21	20½	19¼	19	20¾	21¾	21	+ .21
Fore-Arm	9½	10½	9½	10	9¾	10	9¾	
	9¾	10¾	9½	10	10	10¼	10¼	+ .21
Biceps	9½	10¾	10	9	10	11¼	10¾	
	10	11¼	10¼	9½	10	11½	10¾	+ .32
<i>Right</i>								
Calf	13¾	14	13¼	12¼	14	14½	14	
	14½	14¼	13¼	12½	14½	15	14½	+ .39
Thigh	20¼	20¼	19¼	18½	20	21¾	20¾	
	20¾	20½	19¼	19¼	20¼	21¾	21	+ .28
Fore-Arm	9½	11	9¼	10	10	10	10¼	
	9¾	11¼	9½	10½	10¼	10¼	10¼	+ .25
Biceps	9½	10¾	10	9½	10	11¼	10¼	
	9½	10¾	10¼	9¾	10¼	11½	10¾	+ .18
Waist	28½	28½	27	27¼	27½	29	28½	
	29	29	27¼	28	28½	28½	28½	+ .21
Neck	13¾	15	13½	13½	14¼	13	13¼	
	14	15¾	14	14½	14¼	13	13¾	+ .42
<i>Chest</i>								
Normal	33	34	32	33½	32½	31	34	
	35	36	33½	33¾	34¼	32½	34½	+ 1.46
Expand	34½	36	34	35	35¼	32½	35½	
	38¼	38	35½	37	38	34	36¼	+ 2.32

before and after the training period. In seven muscle groups, muscles of isometric exercisers increased more than those of weight lifters; in five it was the reverse; and in one there was no difference. This seems to indicate that there is little correlation between the two exercise methods and growth of muscle mass in this experiment.

A set of four simple calisthenics was used to determine physical strength and muscle utility. These calisthenics were performed in exactly the same manner before and after the training program. Results are summarized in Table 6.

The most conclusive evidence we have after completing the training program, is in performance of these selected test calisthenics. Boys trained by isometrics showed greater improvement in 3 of the 4 tests (Sit ups, pushups, and jump squats but not pull ups). This variation may have been due to our choice of exercises. However, the training exercises were selected because it was possible to provide identical isometric and isotonic contractions with these exercises. One significant difference is that the isometrically trained boy showed greater improvement in his ability to perform the test exercises after a shorter daily training time than the isotonic trainee. From the lactic acid tests we know that both groups were

working. However, we doubt if the effort among the boys in either group was really maximal. We know that muscle mass increased in both methods of exercise, but this would have occurred no matter what the activity. Since a comparison shows no marked

TABLE 5. *Comparison of Change in Muscle Measurements after Exercise Program in Weight Lifters (W) and Isometric Exercisers (I)*

	Average Change		Difference favoring
	Weight Lifters (W)	Isometric Exercisers (I)	
Weight	+ 3.83	+ 4	I 0.17
<i>Left</i>			
Calf	+ 0.25	+ 0.89	I 0.64
Thigh	+ 0.29	+ 0.21	W 0.08
Forearm	+ 0.21	+ 0.21	0
Biceps	+ 0.58	+ 0.32	W 0.26
<i>Right</i>			
Calf	+ 0.46	+ 0.39	W 0.07
Thigh	+ 0.42	+ 0.28	W 0.14
Forearm	+ 0.21	+ 0.25	I 0.04
Biceps	+ 0.42	+ 0.18	W 0.24
Waist	0	+ 0.21	I 0.21
Neck	+ 0.21	+ 0.42	I 0.21
<i>Chest</i>			
Normal	+ 1.21	+ 1.46	I 0.25
Expand	+ 2.0	+ 2.32	I 0.32

TABLE 6. *Calisthenic Results Before and After Training*

Subject	Sit-up 2 min			Push-up			Squat Jump			Pull-up		
	Before	After	Change	Before	After	Change	Before	After	Change	Before	After	Change
W-1	73	74	1	21	23	2	35	43	8	10	10	0
W-2	68	72	4	24	25	1	35	40	5	12	17	5
W-3	64	64	0	45	50	5	30	55	25	12	15	3
W-4	65	64	-1	21	25	4	31	40	9	11	13	2
W-5	84	88	4	33	42	9	50	57	7	7	9	2
W-6	40	50	10	15	16	1	17	20	3	3	5	2
I-1	58	67	9	3	9	6	10	25	15	2	7	5
I-2	69	87	18	21	33	12	35	59	24	15	18	3
I-3	62	68	6	26	40	14	32	42	10	8	12	4
I-4	55	66	11	30	33	3	39	45	6	13	14	1
I-5	61	64	3	22	25	3	41	41	0	5	6	1
I-6	73	86	13	16	20	4	27	35	8	1	2	1
I-7*	75	81	6	25	20	-5	36	50	14	5	9	4
W Avg	65.67	68.67	3	26.5	30.17	3.67	33	42.5	9.5	9.17	11.5	2.33
I Avg	64.71	74.14	9.43	20.43	25.71	5.28	31.43	42.43	11	7	8.6	1.6

W = Weight lifter; I = Isometric exerciser.

\* One extra boy kept in program.

difference in growth between the groups, we can see no advantage for either in this area in our program.

### Discussion

In this study we wanted to determine whether isometrics or weight lifting was a superior method for increasing muscle strength and mass. We used the lactic acid determination, before the exercising, after the first exercise period and at the end of the experiment, to determine the fact that the exercises had been performed faithfully. We used height, weight, and various body measurements to determine the size changes before and after the exercises. Four test exercises consisting of sit-ups, push-ups, squat-jumps and pull-ups were used to determine the ability of the boys to perform before and after the experiment.

Our study showed a resting lactic acid level of 20.5 to 87.5 mg. per 100 ml. at the beginning. After the first exercise period the levels were 81 to 126 mg. per 100 ml. After the 15 weeks of exercising, levels ranged between 9.5 and 47 mg. per 100 ml. All the lactic acid levels but three at the end were lower after exercising than they were at rest before the 15 week program. This shows the benefit of the exercise to all subjects.

Thirteen tape measurements of the various body parts showed a definite increase in almost all measurements in both groups. In seven of these the isometrics sizes were greater, in five the weight lifters were greater and in one they were the same.

Four exercises were used to measure the performance of strength before and after the program. Ideally, a dynamometer could be used to measure

muscle strength but such a device suitable for the various arm, leg and trunk measurements costs \$300.00 and more. We could not afford this and so used these exercises instead. In the final exercise trial, the isometric exercisers improved more than the weight lifters in three of the four exercises.

### Summary

Isometric exercises were compared with weight lifting in two groups of high school students.

1. All subjects trained well, if maybe not maximally, as evidenced by the reduction in the lactic acid levels.

2. The muscle mass increased more in seven muscle groups with isometric training during this 15 week training period; five muscle groups were greater with weight training; in one there was no difference.

3. In this small study, the boys trained with isometric exercises showed a definite superiority over the weight lifters in performance of three of the four test exercises after the training period.

4. We conclude that isometrics can be done more easily and quickly and generally produce better muscle strength than weight lifting.

**Acknowledgment:** We acknowledge our thanks to the Grid Athletic Company, Division of Jung Products Inc., 312 E. Court St., Cincinnati, Ohio, for financing the program, and our thanks to Frank P. Cleveland, M. D., for performing the lactic acid determinations.

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# Nasal and Pulmonary Disease

## An Essay on Their Interrelation

ELMER R. MAURER, M.D., F. L. MENDEZ, JR., M.D.,  
and RAYMOND L. HILSINGER, M.D.

THE filtering and moisturizing functions of the nasal passages are well known to the thoracic surgeon who spends much of his working hours maintaining an adequate airway occasionally accomplished even by tracheostomy procedures. It is now well accepted by all practicing surgeons that any sudden shunting of the air intake area away from the nasal passages, as for example by tracheostomy, makes it immediately mandatory that artificial humidification, filtering and cleansing programs be instituted. Failure to exercise these precautions invariably leads to crusting and infection in the tracheobronchial ramifications. In some instances these accumulations are so remarkable that bronchoscopic cleanout by way of the tracheostomy opening becomes necessary. In short, any disruption or alteration of the normal flow of air through the nasal passages is invariably reflected in the remainder of the entire ventilatory apparatus, particularly the tracheobronchial tree. Ciliary activity—the built-in automatic cleansing mechanism of the bronchial tubes, mucous gland secretion—the bronchial lubricators, and the bechic blast, so important in the expulsion of secretions, are the most important functions that are impaired.

At this point the stage is set for inspissation and accumulation of tracheobronchial secretions, infection, and in some instances acute suppurative endobronchitis. If emergency evacuation is not instituted the patient may actually drown in his own secretions. Artificial humidification of the tracheostomy atmosphere, installation of antibiotics in buffered saline solutions at regular intervals around the clock, and utilization of some of the new detergent and lytic agents in conjunction with a constant program of tracheobronchial suctioning can prevent most, if not all, of these tracheostomy complications. But pause for a moment and remember that all of these time consuming, expensive, 24 hours a day, drug-laden nursing procedures are never necessary when the same bacteria-loaded room air passes into the same trache-

### *The Authors*

- Dr. Maurer, Cincinnati, is Associate Clinical Professor of Surgery, The University of Cincinnati College of Medicine; Director, Department of Thoracic Surgery, The Christ Hospital.
- Dr. Mendez, Cincinnati, is Associate Attending Member, Department of Thoracic Surgery, The Christ Hospital.
- Dr. Hilsinger, Cincinnati, is Assistant Professor of Otorhinolaryngology, The University of Cincinnati College of Medicine; Attending Otolaryngologist, The Christ Hospital.

obronchial and pulmonary apparatus by way of the nasal passages. What a wonderful, compact "air conditioner" we have!

### *The Nonorganic Intractable Cough and Suppurative Diseases of the Lung*

The thoracic surgeon not infrequently must solve the problem of the persistent intractable cough that responds to no type of therapy in an individual who has been through the usual clinical surveys including roentgenograms of the chest, bronchoscopy, and bronchography, all with entirely normal findings. Almost invariably if the surgeon will take the additional moment to check the paranasal sinuses and the nasal passages his efforts will be rewarding. The constant drainage in patients with rhinorrhea or infected sinuses can be a continuous source of irritation to the trachea and the first portions of the main stem bronchi. In such cases, any endoscopist has had the experience of seeing long strings of tenacious mucus or purulent material hanging from the vocal cords into the trachea or accumulated in the vicinity of the carina and the origin of the main stem bronchi. The mucosal lining of the respiratory passages is basically normal but inflammatory changes are apparent because of the constant lavage by irritating mucopurulent drainage emanating from the upper air passages. Cause of the cough: remote nasal pathology!

This brings us around to the old hackneyed prob-

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Reprint requests to Elmer R. Maurer, M.D., 507 Central Trust Bank Tower, Cincinnati, Ohio 45202.



lem of the interrelationship of sinusitis and bronchiectasis. We are well aware of the not uncommon association of these disorders and the controversies which have arisen regarding whether sinusitis causes bronchiectasis or vice versa. Our personal belief is that both situations prevail. It is possible for constant sinus drainage to eventually produce true surgical bronchiectasis in the emphysematous patient who has a partial loss of the elastic layer in his bronchial tubes, poor pulmonary compliance and consequent poor evacuation of the tracheobronchial ramifications. So also is it possible for the patient with large purulent bronchiectatic reservoirs to infect otherwise normal upper respiratory passages and accessory sinuses by forceful coughing of purulent material into these areas. In such complicated situations the combined efforts of a rhinologist and a thoracic surgeon would certainly be to the best advantage of the patient.

If the disease is determined to be primarily pulmonary in origin then this problem receives first priority control. A particular problem is posed by the patient with an obstructed infected nose associated with a hacking cough, mucopurulent sputum, rales and rhonchi over the lower lobes. Add bronchographic evidence of irregularities in the basal branch bronchi, which are minimal and which would be impossible to categorize definitely as true surgical bronchiectasis, and the problem is compounded. In such an instance it would certainly be erroneous to presume that this patient has true bronchiectasis which is responsible for the poor nasal condition and so proceed straightaway with a lobectomy procedure. It would be much more probable that the mucopurulent drainage from the obstructed nose is responsible for the chronic bronchitis and even intermittent pneumonitis in the basal portion of the lower lobes of the lung and that the bronchographic changes suggesting bronchiectasis are really pseudobronchiectasis secondary to this irritation.

This association of bronchographic irregularities in the peripheral branch bronchi of any particular lobe with active pulmonary disease has long been appreciated by thoracic surgeons. If the pulmonary disease is adequately treated, subsequent bronchographic examination shows complete clearing of the previously described pseudobronchiectatic changes. If this is true, then certainly the pseudobronchiectatic changes would clear entirely, both clinically and

radiographically, following correction of the nasal obstruction and the abnormal drainage from the upper respiratory passages.

### Physiological Implications

A great deal of brilliant work has been done by members of this society on airflow, eddies, heat transfer, humidification or in general, the changes that occur during the movement of air throughout the nose.<sup>1</sup> The delicate relationship between the humidification and warming of the inspired air in the nasal passages and the carbon dioxide and oxygen gas exchange in the pulmonary alveoli has, to our knowledge, never been scientifically explored or measured. It has been pointed out that the movement of air through the nose during inhalation and exhalation is not steady and that the effect of this oscillating flow has some relationship to the total flow delivered to the lungs. Also the ease of the air movement must be a function of the breathing rate. The higher the frequency, the greater is the resistance to change the flow direction.<sup>2</sup>

It has long been accepted as a clinical fact that a patient coughs better against a given resistance. If this balance is distorted the protective function of the cough mechanism is reduced or entirely lost. Pulmonary physiologists have taught us a great deal regarding the relationship of pulmonary function and lung compliance. From these observations, it is obvious that the rhinologist and the thoracic surgeon are superficially aware of the interrelationship between these numerous physiological functions and the numerous factors which must be included in any critical calculation or determination of separate or combined organ function.

In brief, it would seem to us that there is a very large gray zone of unknowns between the nose and the alveoli and that a tremendous amount of information regarding the interrelationship of the physiological functions of the nasal passages and the lungs would almost certainly be the reward of the integrated research efforts of the rhinologist, the respiratory physiologist, and the thoracic surgeon.

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# Obstructive Bronchopulmonary Disease

## The Discrepancy Between Radiologic and Physiologic Findings

WILLIAM R. GRIFFIN, Jr., M.D., and DAN M. DANESHVARI, M.D.

THE prevalence of crippling obstructive pulmonary diseases, especially emphysema, has increased in the past decade, and at present it is estimated ten million known cases exist in the United States.<sup>1</sup>

Clinical examination and chest x-rays have proven inadequate in the early diagnosis and detection of these chronic obstructive pulmonary diseases<sup>2,3,4</sup>; nevertheless, clinicians are prone to exclude these diseases on the basis of a normal posteroanterior chest x-ray.

This present study was undertaken to compare the results of simple pulmonary function studies with routine posteroanterior chest films in the diagnosis of obstructive bronchopulmonary disease.

### Method

The records of patients at Mount Carmel Hospital who have had routine chest x-rays and pulmonary function studies during the past 18 months were analyzed. These patients were from two sources: (1) patients referred to the Cardiopulmonary Laboratory by the attending physicians for primary function study; and (2) patients referred for secondary function studies after an x-ray diagnosis of obstructive bronchopulmonary disease. Patients were excluded from this study if more than seven days had elapsed between the chest x-ray and the pulmonary function tests. A final group of 86 patients was chosen, consisting of 70 men and 16 women ranging in age from 36 to 79 years. Each patient had a routine 14 by 17 inch posteroanterior chest film taken and interpreted by the hospital radiologist.

All pulmonary function studies were supervised by one of the authors. These consisted of (1) vital capacity (VC), (2) one, two, and three second timed vital capacity, (3) total timed vital capacity, (4) maximum breathing capacity (MBC), and (5) chest fluoroscopy.<sup>5,6</sup> The pulmonary studies were done with a Collins nine liter respirometer. During fluoroscopy, special attention was given to diaphrag-

### The Authors

- Doctor Griffin, Columbus, is the Chief Administrative Resident in Medicine, Mount Carmel Hospital.
- Doctor Daneshvari, Columbus, is a member of the General Medical Staff of Mount Carmel Hospital and serves as Consultant to the Cardiopulmonary Laboratory of Mount Carmel Hospital.

matic excursion, air trapping on forced expiration, and expansion and motion of the thoracic cage.

The chest x-ray interpretations were taken from the radiologist's report. Radiographic evidence of obstructive bronchopulmonary disease on the basis of a single posteroanterior chest film consisted chiefly of overinflation of the lungs and/or a depressed diaphragm. The final diagnosis of those films considered to be positive varied from chronic bronchitis to emphysema of a mild, moderate, or severe degree.

Pulmonary function studies (PFS) were classified as being normal or indicative of mild, moderate, or severe obstructive ventilatory impairment. *Mild obstruction* was considered to be present if the patient had a decreased expiratory air flow (total timed vital capacity greater than six seconds) combined with a maximum breathing capacity of from 75 to 80 per cent of the predicted normal. *Moderate obstruction* was defined as being present in patients with a delayed one, two, and three second timed vital capacity and total timed vital capacity of more than six seconds with a maximum breathing capacity of less than 75 per cent. Finally, *severe obstruction* was considered to be present in those patients with a markedly reduced one, two, and three second timed vital capacity and delayed total timed vital capacity with a maximum breathing capacity of less than 50 per cent.

### Results

Of the 86 patients evaluated, 46 were reported to have x-ray evidence of obstructive bronchopulmonary

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disease. The remaining patients showed no radiologic evidence of obstructive pulmonary disease.

Of the 46 patients with positive x-ray findings, 26 (56.6 per cent) showed pulmonary function study evidence of severe obstructive impairment, 13 (27.3 per cent) gave evidence of moderate obstructive impairment, two (4.3 per cent) showed mild obstructive impairment and five (10.9 per cent) had pulmonary function studies within normal limits (Fig. 1).

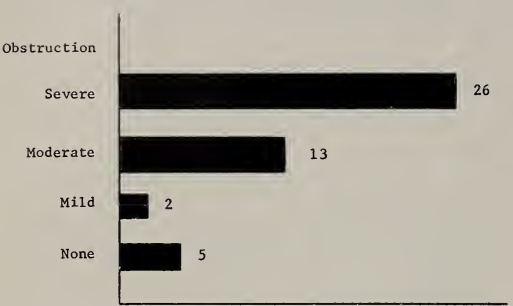


FIG. 1. Pulmonary Function Studies in 46 patients with "emphysema" on PA chest x-rays

Of those 40 patients with negative x-ray findings, nine (22.5 per cent) showed severe obstructive functional impairment, 22 (55 per cent) showed moderate obstructive impairment and nine (22.5 per

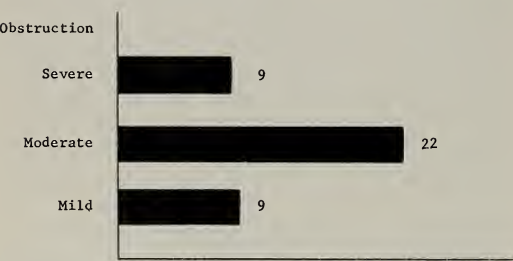


FIG. 2. Pulmonary Function Studies in 40 patients with "normal" PA chest x-rays

cent) showed evidence of mild obstructive impairment. These findings are summarized in Figure 2.

Discussion

Knott and Christie<sup>7</sup> showed in their study in 1951 that a radiologic diagnosis of emphysema based on a single posteroanterior chest film was of doubtful reliability. Their series consisted of 20 patients with clinical emphysema and 20 normal controls. Four radiologist observers agreed on a diagnosis of emphysema based on a single posteroanterior chest film in 75 per cent of the patients in the emphysematous group. In the normal control group, however, only 40 per cent were passed as normal by all the observers. Our studies verify the impression that there is a discrepancy between radiologic and physiologic findings in chronic obstructive pulmonary disease.

The failure of correlation between pulmonary

function studies and x-ray findings is illustrated by the following cases:

Illustrative Case No. 1

A 44 year old white man was admitted for evaluation of his cardiovascular status. A posteroanterior chest film taken on admission was interpreted as showing moderate emphysema. Pulmonary function studies showed a vital capacity of 142 per cent of predicted normal, a total timed vital capacity of only 4½ seconds, and a maximum breathing capacity of 97 per cent. This man was tall and slender, and

TABLE 1. Abnormal X-Ray—Normal Physiologic Findings

	Case 1	Case 2	Case 3	Case 4	Case 5
Vital Capacity .....	142%	110%	111%	115%	116%
Total Timed Vital Capacity .....	4.5 sec.	6 sec.	3 sec.	6 sec.	4 sec.
Maximum Breathing Capacity .....	95%	116%	107%	100%	110%

the increased vital capacity gave a radiologic picture of low flat diaphragms on inspiration.

The findings in patients with positive chest x-rays and normal physiologic findings are summarized in Table 1.

Illustrative Case No. 2

A 65 year old white man, a heavy smoker with a chronic cough of many years' duration, was admitted for evaluation of shortness of breath with a clinical diagnosis of severe pulmonary emphysema. A chest film was reported to be within normal limits. At chest fluoroscopy, both hemidiaphragms were limited in excursion, moving only 2 centimeters on quiet and 3 centimeters on deep breathing, as compared to the expected 4 to 10 centimeters. Expansion and motion of the thoracic cage were limited with an increase in the width of intercostal spaces and in the anteroposterior diameter of the chest. The lungs were overinflated and showed evidence of air trapping. The diaphragms were not markedly depressed but were flat. Pulmonary function studies showed a vital capacity of 76 per cent of predicted normal. The total timed vital capacity was 12½ seconds, the maximum breathing capacity was 37.3 per cent.

The findings of the nine patients with normal chest x-rays and positive pulmonary function studies for obstruction are summarized in Table 2.

In patients with radiologic evidence of obstructive bronchopulmonary disease and normal pulmonary function studies, the discrepancy is probably due to apparent overinflation of the lungs with the diaphragms lying at the level of the 11th or 12th ribs posteriorly on the single inspiratory posteroanterior chest x-ray. This by itself, however, is not sufficient evidence to warrant the diagnosis of emphysema or chronic bronchitis. Factors such as the body build of the patient may be responsible for this appearance, persons who are tall and slender being particularly prone to have this type of x-ray pattern.

At the other extreme are those patients with normal x-ray findings but marked physiologic evidence of obstructive ventilatory impairment. Patients with severe chronic bronchitis may show no increase in total lung volume, so that a posteroanterior chest x-ray on full inspiration will not show the character-

TABLE 2. *Normal Chest X-Ray—Severe Obstructive Disease*

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9
Vital Capacity	76%	82%	91%	71%	65.4%	91%	53.7%	50.8%	71.4%
Total Timed Vital Capacity	12.5 sec.	11 sec.	8 sec.	10 sec.	14 sec.	14 sec.	10 sec.	11 sec.	12 sec.
Maximum Breathing Capacity	37.3%	43%	43.9%	40.5%	39.2%	43.2%	22.8%	27.4%	44.4%

istic picture of low flat diaphragms or hyperinflation. If no fibrosis or parenchymal infiltration is present such x-ray films may well be interpreted as being within normal limits.

Patients with a mild to moderate degree of physiologic obstructive ventilatory impairment may also exhibit normal radiographic findings until late in the course of their disease. If such patients are to be identified and effective therapy initiated at the earliest opportunity, screening posteroanterior chest x-rays alone are not sufficient. Simple pulmonary function studies and critical chest fluoroscopy, in conjunction with the screening chest x-ray, can identify these patients in the early phases of their disease, and such combined study is to be strongly recommended.<sup>8</sup>

### Conclusions

1. There is frequent discrepancy between radiologic findings and pulmonary function findings in patients with chronic obstructive bronchopulmonary disease.

2. A normal posteroanterior chest x-ray does not rule out the presence of obstructive bronchopulmonary disease; indeed, such a patient may have severe obstructive ventilatory impairment.

3. If chronic obstructive bronchopulmonary disease is to be diagnosed early, simple pulmonary function studies as described above, consisting of the vital capacity, the one, two, and three second timed vital capacity, the total timed vital capacity, the maximum breathing capacity, and chest fluoroscopy, must be combined with the routine posteroanterior chest x-ray.

4. Inspiratory and expiratory posteroanterior and lateral chest x-rays may be more accurate in the detec-

tion of obstructive bronchopulmonary disease than the single inspiratory posteroanterior chest film, but the simple physiological tests are still required for early identification.

### Summary

Eighty-six patients with concurrent chest x-rays and pulmonary function studies were examined. Of 40 patients with reportedly normal x-ray findings, all showed some degree of obstructive ventilatory impairment ranging from a mild to severe degree. Of 46 patients with radiologic evidence of obstruction, five showed no evidence of physiologic obstruction. There was a wide discrepancy between the radiologic and physiologic findings in individual patients.

A combination of simple pulmonary function studies, including chest fluoroscopy, in conjunction with the screening posteroanterior chest film is suggested for the early detection of obstructive bronchopulmonary disease.

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# Hodgkin's Sarcoma of the Heart

## Report of a Case Simulating Myocardial Infarction

LEONARD J. JANCHAR, M.D., and MAURICE L. SNELL, M.D.

THIS case of recurrent Hodgkin's sarcoma with an isolated metastatic focus in the myocardium eight years after removal and apparent cure was also unusual in its clinical manifestations and in the electrocardiographic changes it produced.

### Case History

A 69 year old white man was admitted to the Barberton Citizens Hospital on September 13, 1963 complaining of oppressive chest pain, difficulty in breathing, and a sense of coldness. During the year prior to admission, exertional dyspnea and substernal pain relieved by rest had become progressively more severe. No edema or nocturnal dyspnea had been noted. The system review was otherwise noncontributory. Eight years prior to admission, a large 6 by 6 cm. subcutaneous mass was removed from the left infrascapular area, and a microscopic diagnosis of Hodgkin's sarcoma made. Intensive x-ray therapy was given to the operative site and over the subsequent eight years there was no recurrence.

Physical examination on admission revealed an apprehensive, dyspneic, sweating, extremely cold white man with temperature 97.8°, blood pressure 78/60, and pulse rate 92 with frequent ventricular extrasystoles. The neck was normal. The lungs were resonant and clear. The apical impulse was displaced to the left, a soft grade 2 systolic apical murmur was present, and  $A_2$  was greater than  $P_2$ . No splenomegaly or lymphadenopathy was present. The operative site in the left infrascapular area was scaly with telangiectasis but no tumor was evident. The remainder of the physical examination was normal.

The initial electrocardiogram (Fig. 1) revealed anterior ischemia, first degree atrioventricular block, frequent premature ventricular systoles, and ventricular tachycardia (Lead  $V_6$ ). With the use of Aramine® (50 mg. in 500 cc. 5 per cent glucose in distilled water) and quinidine sulfate 6 grains every two hours, the tachycardia and hypotension were corrected, reversion to normal sinus rhythm occurred, (Fig. 2), but abnormal T wave inversion and first degree atrioventricular block persisted. Serial heart transaminase determinations were 220, 91 and 61 units respectively. Cholesterol was 220 mg., blood urea nitrogen 18 mg., fasting blood sugar 118 mg., sodium 137 milliequivalents, potassium 3.8 mEq,

### The Authors

- Dr. Janchar, Barberton, is Chief, Division of Medicine, Barberton Citizens Hospital.
- Dr. Snell, Barberton, is Director of Laboratories, Barberton Citizens Hospital.

chloride 108 mEq, and carbon dioxide 25 mEq. Red blood cell count was 4.5, hemoglobin 14.6 Gm., hematocrit 45 vol per cent and white blood cell count 12,000 with normal differential.

The clinical history, laboratory results and electrocardiogram changes were consistent with non-transmural infarction. Coumadin® was administered and Demerol® given for pain. Clinical progress was satisfactory and the patient was discharged two weeks after admission. A chest x-ray was normal except for left ventricular hypertrophy.

The patient was readmitted six weeks later in congestive heart failure, complaining of oppressive chest

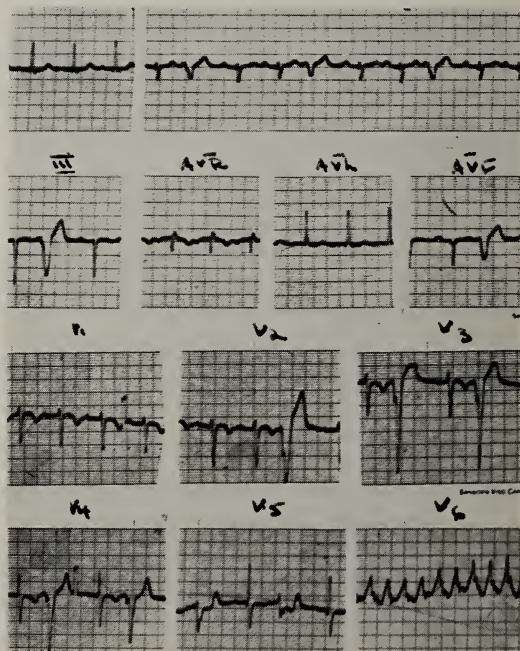


FIGURE 1

Submitted May 4, 1964.



pain. Again, ventricular tachycardia with a rate of 240/minute was present on the initial electrocardiogram. Conversion to normal sinus rhythm was accomplished again with quinidine 6 grains every two hours, but right bundle branch block with abnormal Q waves in the antero-septal leads was now present (Fig. 3) indicative of myocardial infarction. Serial

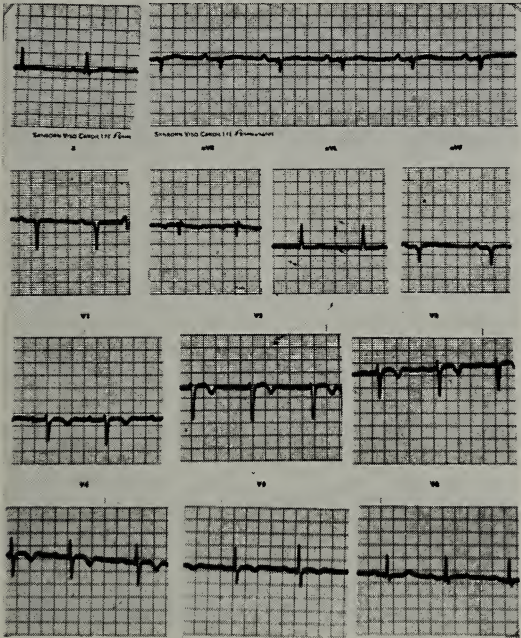


FIGURE 2

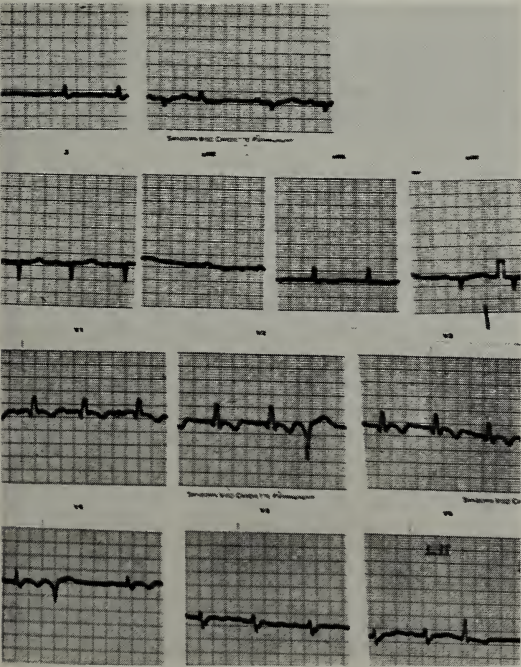


FIGURE 3

heart transaminase determinations were 19, 85 and 29 units respectively. A portable chest x-ray revealed pulmonary edema and the heart to be enlarged in all diameters. After treatment with digitalis and mercurial diuretics, rapid clearing of the congestive heart failure ensued. The patient was asymptomatic after the second hospital day but, on the seventh day, he developed ventricular fibrillation (Fig. 4) and died despite attempts at resuscitation.

Postmortem Examination

At autopsy, no significant external abnormalities were noted. Within the right pleural cavity, there were massive fibrous adhesions. No pleural fluid was seen. Forty cc. of amber fluid was noted in the pericardial cavity. The heart was enlarged, weighing 700 grams. The enlargement was symmetrical, the right ventricle measuring 1 cm. while the left measured 3 cm. in thickness. The myocardium, however, exhibited a marked transformation, being a yellow-gray rather firm tissue, which did not grossly appear to be an area of infarction. It appeared rather to be tumor. This area of alteration involved the anterior two-thirds of the interventricular septum together with the anterior wall of the left ventricle and the posterolateral aspect. The endocardial surface was also roughened and had fresh blood clot adherent to it. Both lungs were congested and edematous. The spleen was enlarged, weighing 600 grams. The liver was enlarged, weighing 1900 grams and exhibiting central congestion. There was no significant lymph-

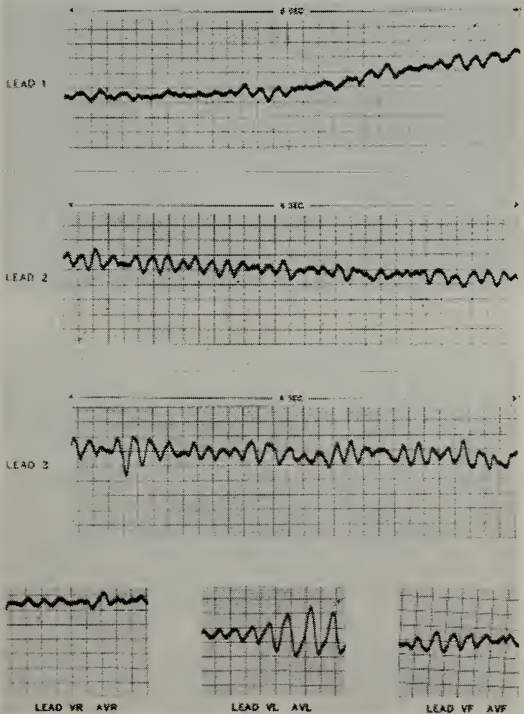


FIGURE 4



adenopathy noted. One iliac lymph node was submitted for examination.

The gross appearance of the heart showed diffuse replacement by tumor as seen in figure 5. The microscopic examination of representative areas throughout the heart showed a reduplication of all fields. The essential picture was that of some fairly definitive pleomorphism of a mononuclear cellular infiltrate admixed with areas in which eosinophils are detected and in which good numbers of Reed-Sternberg giant cells are defined. Mononuclear cells show a fair degree of variation in size and shape and frequently possess rather reniform shaped nuclei. Lymphocytes and plasma cells are also identified



FIGURE 5

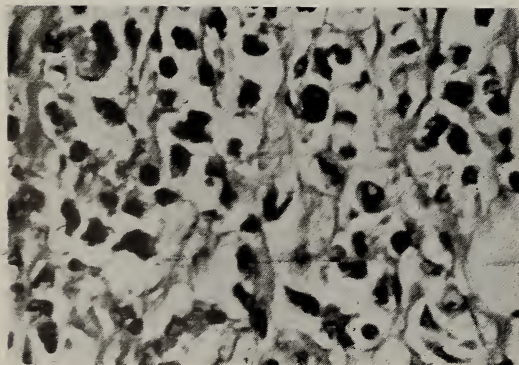


FIGURE 6

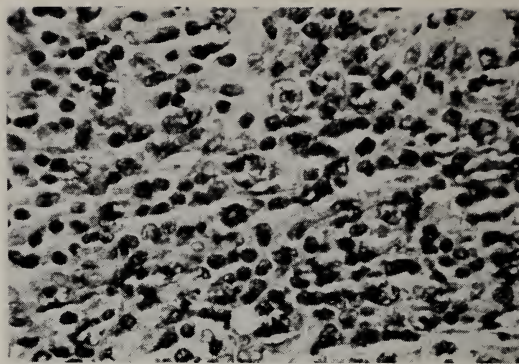


FIGURE 7

throughout the various sections. These are demonstrated in figure 6. Examination of all the remaining organs fail to reveal any evidence of a similar histologic picture. The splenic sections showed areas of isolated hematopoiesis as did the liver sections. The cellular infiltrate noted in the heart, however, was not identified in these sections. The lymph node examined shows no evidence of a lymphoma.

In retrospect the history was then obtained of a diagnosis eight years prior to his death, of Hodgkin's sarcoma, noted in a lesion removed from the patient's back. Fortunately, the slides of that lesion were located and were examined at this time. The histologic findings are represented in figure 7. Here again, there is a pleomorphic picture with the presence of mononuclear cells and Reed-Sternberg giant cells together with eosinophils, lymphocytes, and plasma cells consistent with Hodgkin's sarcoma. The lymphocytes and plasma cells are noted with some difficulty and the extreme pleomorphism of the picture is suggestive of a high degree of malignancy. The histologic pictures of the original lesion compare favorably with those of the myocardial lesions noted at autopsy.

#### Summary

This report describes the coexistence of Hodgkin's sarcoma of the myocardium in a 69 year old white man with marked coronary arteriosclerosis but no demonstrable myocardial infarct despite coronary type chest pain, repeated ventricular tachycardia, elevated heart transaminase determinations, congestive heart failure, and electrocardiographic changes of myocardial infarction. The unusual nature of the case in which an apparent Hodgkin's sarcoma recurs eight years later as a myocardial metastasis seems unparalleled and would appear to deem this case worthy of report.

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# Acute Pulmonary Edema

MARVIN FISH, M. D.\*

**A**CUTE pulmonary edema is a state characterized by infiltration of serum into the interstitial pulmonary tissue followed by filling of the alveoli and many bronchial spaces with serous or sero-sanguinous fluid. It occurs in a wide variety of disease states (see Table.) One or more of the following functional disturbances are implicated: *A.* Increased pulmonary capillary pressure, aggravated by impaired pulmonary lymphatic drainage (acute left ventricular failure of mitral block); *B.* Increased lung capillary permeability (inhalation of noxious fumes); *C.* Increased negative intrapulmonic pressure (severe inspiratory airway obstruction); *D.* Severely decreased plasma colloid pressure (severe hypoproteinemia) is rarely the sole cause of pulmonary edema.

Initially, oxygen diffusion from alveolus to pulmonary capillary is impeded by interstitial edema. With the formation of a foamy exudate in the alveoli, oxygen transport is further disturbed by abnormal ventilation perfusion relationship.<sup>1</sup>

## Conditions Known To Produce Pulmonary Edema<sup>2</sup>

Left ventricular failure	Thyroid crises
Mitral stenosis	Shock
Renal insufficiency, azotemia	Inspiratory airway obstruction
Brain damage	Hypersensitivity reaction
Toxemia of pregnancy	Acute blood loss followed by
Pulmonary embolism	fluid overload
Pulmonary infection	Toxic drug or chemical reaction
Lung inflammation, noninfectious	Severe burns
Anoxia	Drowning

Despite the urgency of the situation, clinical history and examination are of utmost importance and are carried out with dispatch while therapeutic measures are marshalled. Clinically, there is profound dyspnea, severe anxiety and restlessness; sometimes stupor. Chest discomfort and cough, and pink frothy sputum is the rule. Tachypnea, cyanosis, neck vein distention, bounding pulses and elevated blood pressure are observed. Occasionally, hypotension and shock supervene. Extreme care is necessary to exclude an asthmatic attack in which case morphine would be very hazardous. Likewise, epinephrine, beneficial in asthma, is contraindicated in acute pulmonary edema.

Ten to fifteen mg. of morphine intramuscularly or intravenously is of value in decreasing the respira-

tory drive, whether it be by central nervous system depression or by allaying apprehension. Immediate treatment of hypoxia reduces the work of breathing and improves cardiac function. Where oxygen is not available it should be immediately summoned and continued while the patient is transported to the hospital. Adequate oxygenation can be achieved by the use of 100 per cent O<sub>2</sub> using a well-fitting face mask and high oxygen flow (10 to 15 liters per minute). Nasal catheter and cannulas rarely permit adequate O<sub>2</sub> concentration. Meter masks (expiratory positive pressure), though originally designed for treatment of pulmonary edema, increase the work of breathing and are best avoided.

One hundred per cent oxygen administered by intermittent positive pressure breathing (IPPB/I) is singularly the most effective approach to treatment. Advantages of IPPB/I are many, the chief of which is marked improvement of alveolar ventilation. It affords immediate relief of hypoxia, reduces work of breathing, and improves cardiac function and pulmonary lymphatic flow. The resultant increased intra-alveolar pressure encourages flow of fluid back into the pulmonary capillaries. Venous return to the heart is effectively reduced. Regulation of the inspiratory mask pressure allows titration of the amount of blood dammed back or released into central circulation.

The sidearm nebulizer should contain 3-4 cc. of 20 per cent ethyl alcohol and 0.5 cc. of Isuprel®; an effective antifoaming agent and bronchodilator. Used alternately at 30 minute intervals with distilled water it is less likely to cause bronchial irritation. In general, inspiratory masked pressure settings should not exceed 20-25 cm. of water and should be reduced to 8-10 cm. if there is hypotension. Currently available machines have incorporated a negative mask pressure phase during expiration, which is helpful in maintaining cardiac output when hypotension or shock occur. Though the mechanism of shock in pulmonary edema is not clearly defined, prompt elimination of hypoxia will frequently correct hypotension without the use of vasopressors.

One hundred per cent oxygen with IPPB/I markedly lessens the need for phlebotomy, tourniquet venous occlusion or pharmacological reduction of venous return. The rapid removal of 300 to 500 cc. of blood can be helpful, particularly in cases of fluid

The Heart Page is a periodic feature of *The Journal* containing brief, practical comments on subjects of immediate importance to practicing physicians. The comments are solicited by the Professional Education Committee of the Ohio State Heart Association.—Ed.

\*Dr. Fish, Columbus, is a member of the Senior Attending Staff, and Director, Pulmonary Function Laboratory, Riverside Methodist Hospital; Clinical Instructor, Department of Medicine, The Ohio State University College of Medicine.



overload and even in the presence of mild or moderate anemia, but should not be done in the presence of acute myocardial infarction or hypotension. Cautious, continuous Arfonad® infusion (0.1 mg./cc.) producing splanchnic blood pooling is useful when there is marked arterial hypertension. The application of three rotating tourniquets is far less likely to encourage shock. Arterial pulsations must not be obliterated, and the straps must be rotated every 15 minutes.

When acute pulmonary edema is clearly the result of myocardial insufficiency aminophylline, 500 mg. intravenously, serves to dilate bronchioles, decrease pulmonary artery pressure, and improve myocardial contractility. Rapid intravenous digitalization with 1.2 mg. of Cedilanid® is carried out in the previously undigitalized cardiac. In the presence of shock,

digitalis may aggravate myocardial irritability but is still advisable, though in a lower dose (0.8 mg.). A mercurial diuretic may be given for its delayed action.

It is strongly emphasized that rapidly effective measures to allay apprehension, correct hypoxia, and, when necessary, reduce venous return have precedence over the "routine" administration of cardiotonic drugs, bronchodilators, and diuretics. The latter can generally be withheld until more deliberate diagnostic measures uncover the etiology of the attack and point to rational specific and/or supportive therapy.

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**RENAL-ARTERY STENOSIS.**—Two cases demonstrate a characteristic sign which adds to the value of intravenous urography in the investigation of hypertension. The periureteral arterial plexus serves as an arterial communication between the renal artery and branches of the abdominal aorta. These vessels are too minute to be seen on arteriography but become evident when they increase in size as collateral channels to the ischemic kidney in the event of renal-artery occlusion or in conditions such as chronic pyelonephritis, tuberculosis, and renal carcinoma.

Few conditions can cause ureteric irregularities as seen on urography, but if this radiological picture is associated with hypertension it should strongly suggest the diagnosis of renal-artery stenosis. — H. O. Wong, M. B., M. R. A. C. P., and K. W. Chow, M. B., M. R. C. P. GLASG., Singapore: *British Medical Journal*, p. 418, February 15, 1964.

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# Correctable Renal Hypertension

## X. Surgical Treatment (continued)

CHESTER C. WINTER, M.D.\*

PRIOR to renal revascularization for correction of renal hypertension, the pressure gradient across the arterial constriction should be ascertained. This is performed by inserting needles into the aorta and distal renal artery and comparing their mean pressures. If a gradient is not present, it is doubtful that surgery will be beneficial. Surgical opinion is polemic as to the critical gradient necessary to indicate a favorable response to operation; proposed figures vary from 5 to 50 mm of mercury. Following the surgical procedure, pressure readings should be taken again to see if the gradient has been erased.

The sagacious surgeon will take biopsy specimens from the upper and lower poles of each kidney or in the segmental areas involved at the time of operation; such minor excisions are innocuous. It is anticipated in the future that immediate examination of surgical biopsies prepared by quick freezing will be useful to reveal changes in the juxtaglomerular apparatus, pathognomic of the renal origin of the patient's hypertension. Studies of renal biopsies are currently applied to the evaluation of methods in the investigation of renal hypertension and to determine whether the lesions are truly involved. Biopsies also assume a puissant role when an exacerbation of hypertension occurs in the postoperative period and further renal surgery is under consideration.

Segmental renography may be carried out in the operating theater by placing miniature scintillation probes over each segment of the exposed kidney. The maneuver increases the accuracy in identifying the areas involved in renal ischemia. In the postoperative period, renography is adaptable to recovery room use as well as to the patient's bedside for monitoring renal blood flow and kidney function after vascular surgery. This is the only reliable and repeatable test available to detect early thrombosis of the renal artery after surgery.

A definition of surgical cure of hypertension is desirable, although opinions on criteria differ among surgeons. The most rigid requirement is that the

blood pressure is lowered to 140/90 mm of mercury or less. In addition, it should return to normal within a few weeks after the operation and be maintained at this level for at least one year postoperatively. Less rigid demands would allow a reduction of vascular pressure only to 160/90 mm. A review of case reports discloses that many patients considered cured had marked drops in blood pressure after surgery but not to the levels just described as desirable. One British clinician would settle for a 20 per cent decrease in diastolic blood pressure and cites as an example a patient's diastolic reading dropping from 140 to 105 mm of mercury where it remained for 17 years during a useful life.

For purposes of this discussion we adopt the criterion of curability as being a blood pressure no greater than 160/90 mm. Beneficial results falling short of surgical cure are desirable and include a significant drop in vascular pressure, amelioration of symptoms, return of heart size toward normal and reduction of grade IV retinopathy. Many patients improve immediately after surgery regardless of whether renal surgery or revascularization has been performed. Improvement is attributable to bed rest, blood loss, sedatives and anesthesia.

It is wise, therefore, not to make a judgment as to the result of surgery until the patient is seen through the third postoperative month. An immediate drop in blood pressure upon clamping the renal artery is thought to be of special significance. This would seem to be an indication that the source of renin is instantly shut off from the circulation. A precipitous drop in blood pressure may threaten the life of the patient, especially if he is in the older age group in whom a gradual reduction in pressure would be kinder to the cerebrum and myocardium, where vessels may be impaired by varying degrees of atherosclerosis.

The discussion of results of surgical treatment of renal hypertension will be continued in the next fascicle of this series.

### Reference

*Correctable Renal Hypertension*, Philadelphia, Lea and Febiger, 1964.

\*Dr. Winter, Columbus, is Professor of Surgery and Director of Division of Urology, The Ohio State University Hospitals.



# A Clinicopathological Conference

From The Children's Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT G. THOMAS, M.D., *President*

## PRESENTATION OF CASE

THIS white boy, aged 3 days, was born in a community hospital of a gravida III, Para II, abortus I, 29 year old white mother. The baby weighed 8 lb. 10 oz. at birth. Except for minimal ankle edema the pregnancy and delivery were uneventful. Following birth the child regurgitated frequently. The vomitus was not known to be bile-stained. He was said to have had some "choking" with feeding of an evaporated milk formula. On the second day of life he had 6 to 8 loose stools, showed some circumoral cyanosis, and on the day of admission fresh blood was noted in each stool. He had a temperature of 103° F. and was transferred to Columbus Children's Hospital.

### First Admission

The temperature was 100.4°, pulse rate 148 per minute, respiratory rate 36 per min., weight 7 lb. 10 oz. The baby appeared alert and quiet with minimal spontaneous movement and did not appear to be in distress. He showed some circumoral cyanosis with deep crying. The skin appeared mildly jaundiced. Examination of the ears, nose and throat was not remarkable. The lungs were not remarkable, and the heart was not enlarged. The abdomen was soft and the liver edge palpable. The femoral pulses were described as weak but present. The child showed a good suck, grasp, Moro, and rooting reflex. The deep tendon reflexes were physiological. Rectal examination showed a large fissure to be present.

On admission the hemoglobin was 19.7 Gm., the white blood cell count 14,500 with a differential of 7 per cent band forms, 54 per cent segmented neutrophils, and 39 per cent lymphocytes. Urinalysis gave normal findings. Stool culture No. 1 yielded a *Staphylococcus pyogenes*; culture No. 2 showed no enteric pathogens. Stool inoculated two days later showed a pure culture of yeast forms. Culture of the umbilicus yielded *Staph. pyogenes*; phage could not be typed. Blood culture on admission yielded no growth.

The baby was treated with neomycin and given boiled skim milk and improved promptly. He developed a red umbilicus on the second hospital day.

## Presented by

- M. L. Robbins, M.D., Columbus, and
  - W. A. Newton, Jr., M.D., Columbus.
- Edited by Dr. Newton.

With erythromycin this cleared. The stools decreased from eight to two per day and changed from watery to soft. After a short stay he was discharged home with a diagnosis of parenteral diarrhea.

At home, however, he continued to have increased numbers of loose stools with much mucus content. About two weeks after discharge the child began vomiting 24 hours after onset of rhinorrhea but was afebrile.

### Second Admission

The child was readmitted at that time. Physical examination showed a weight of 7 lb. 10½ oz. The skin showed good turgor. The fontanel was slightly sunken. The pulse rate was 180 per min., respiratory rate 48 per min. The abdomen was distended but soft. Large firm intestinal loops were palpable. The bowel sounds were hyperactive and high-pitched. Laboratory studies showed a hemoglobin of 16.9 Gm., white blood cell count 12,800. The urine was essentially normal. The blood urea nitrogen was 18 mg. per 100 ml.; CO<sub>2</sub> was 18, chlorides 106, sodium 144 mEq./L. One stool culture yielded no enteric pathogens. Recumbent and upright films of the abdomen showed multiple dilated loops of bowel with fluid levels present. There was no evidence of free peritoneal fluid. Barium enema was interpreted as showing no evidences of mechanical obstruction. The child was treated conservatively with intravenous fluids. The abdomen became less distended. He was seen by a surgical consultant, who felt there was no evidence of pyloric stenosis. He was given Mycostatin®. The child's temperature course was within normal limits except for one spike to 103°F. His weight remained at approximately 7 lb. 10 oz.

### Third Admission

His third admission was at 3 months of age when he again had diarrhea three days after the onset of

rhinorrhea and vomiting. On the day of admission he refused food and had 10 to 15 watery yellow stools. His weight before the onset of diarrhea was 12 lb. 10 oz., in the pediatrician's office it was 12 lb. 1 oz., and on admission, 11 lb. 14 oz. Physical examination showed a temperature of 102°F. He appeared dehydrated but had good skin turgor. The abdomen was slightly distended. The bowel sounds were somewhat decreased. Laboratory studies showed a hemoglobin of 11.5 Gm. and white blood cell count of 10,300, a normal spinal fluid, negative urinalysis, blood urea nitrogen 8 mg., CO<sub>2</sub> 20 mEq./L. Stool and blood cultures showed no growth. He was treated with intravenous fluids, and his temperature returned to normal. He was discharged four days later.

After this admission the child appeared to be continuously constipated. The mother gave him several enemas and administered rectal suppositories in order to obtain adequate bowel movements. This persisted until two weeks prior to the last admission, at 6½ months of age, when he began to develop diarrhea. A sibling was said to have had a virus infection at the time. The diarrhea lasted a few days and improved. However, three days prior to the final admission his abdomen became considerably distended; he appeared to have abdominal pain, began refusing feedings, and was increasingly listless. On the day of admission projectile vomiting started. The vomitus was green and "smelled like bile."

#### Final Admission

On physical examination his weight was 14 lb. 11 oz., temperature 103.6°F., pulse rate 144 per min., respiratory rate 36 per min. He was given parenteral fluids, antipyretics, and neomycin. He passed frequent large soft yellow stools. At 1:20 a. m. of the second hospital day the temperature was 104.8°F., and it was noted that the right leg was twitching. There was cyanosis of the hands and feet. The CO<sub>2</sub> was 12, sodium 130, and potassium 5.6 mEq./L. He had received approximately 700 ml. of intravenous fluids over the previous 24-hour period consisting mostly of Levugen® No. 75. He was given 30 mg. of sodium Amytal® intravenously and saline, and the convulsions stopped. A barium enema was performed. A surgical consultant felt that the child needed intensive supportive therapy and if possible a colostomy, and he was transferred to the surgical service. Blood transfusion was given followed by plasma. He was given penicillin and streptomycin. The child was never considered to be in sufficiently good condition for surgery and he died five days after his final admission.

#### CLINICAL DISCUSSION

DR. ROBBINS: On the first admission the baby was 3 days of age and presented with mild diarrhea, jaundice, and fever, probably on the basis of sepsis. He was treated for the diarrhea and given an

antibiotic for a staphylococcus which was grown from the navel. I don't know what to make of the staphylococcus in the first stool and the pure yeast forms in the second. His birth weight was 8 lb. 10 oz. and when he was admitted at 3 days of age it was 7 lb. 10 oz. A pound weight loss is perhaps a little more than we would expect normally, but is consistent with sepsis and diarrhea in the newborn period. There was one other point in that the bloody stools evidently were related to a large fissure. The baby responded very well and was sent home without any complications.

After discharge he again started with the diarrhea; his stools were loose with a great deal of mucus. We don't know what type of feeding the baby was given. Some babies are sensitive to cow's milk and have mucous stools. We have no history of any change in the formula. Sensitivities to various formulas are one of the causes of diarrhea. The child began vomiting about two weeks after discharge and was readmitted. The baby was only mildly dehydrated but the abdomen was distended. Large, firm intestinal loops were palpable and hyperactive, and high-pitched bowel sounds were heard. This would appear to be a recurrence of gastroenteritis. Unless I was impressed with the tremendous distention of the abdomen I would not have ordered the next study, which was a barium enema. Dr. Howard, would you want to show that barium enema now?

DR. HOWARD: The anteroposterior film of the abdomen shows rather marked bowel dilatation. This is not a pattern of mechanical obstruction as far as we can tell. Even so, in the upright view there are a few air/fluid levels. With this type of bowel pattern you cannot tell whether or not this is a mechanical obstruction. You also don't know whether you are looking at large or small bowel, so we felt that the next step should be a barium enema in an effort to get more definite information. The barium enema shows some irregularity and apparently there was some irritability while this was going on, and the fluoroscopist interpreted this as being due to an enterocolitis, or the type of pattern that we see in patients with an enterocolitis.

DR. ROBBINS: In summary then, this baby was readmitted afebrile, with diarrhea, vomiting, and distention. The child responded to supportive therapy and was discharged with a weight of 7 lb. 11 oz. This is not a very good weight gain in view of the birth weight of 8 lb. 10 oz. During the nine weeks between the second and third admissions all we know is that he had gained 5 lb., so that I would assume that this child did perfectly well. A weight gain of 5 lb. was quite good and I think had I been the pediatrician at this time I would have considered the two incidental episodes as gastroenteritis and I would not have been too worried about this child.

The third episode started following the onset of a



runny nose, watery yellow stools, a very rapid loss of weight, and a temperature of 102. The child appeared dehydrated and slightly distended. The laboratory studies at this time still showed nothing of significance. The stool cultures taken failed to reveal the cause of this child's diarrhea and vomiting. In a child with recurrent diarrhea I might start thinking in terms of fibrocystic disease or some other chronic intestinal infection. I probably would have looked for ova or parasites in the stool, but still the baby had gained weight well and evidently its feeding pattern was normal between admissions and in a two-month period there is no reason why this child could not have had another incidental infectious diarrhea.

Now we come to a change in the child's pattern and some information as to what happened in between hospital admissions. When he was discharged at about 3½ months of age and was home for the next three months he became continuously constipated and had to be treated with several enemas and rectal suppositories to insure adequate bowel movements. It would have been of value to know just about how often enemas had to be used, how severe the constipation was at this time, and what other measures were used, and something about the general condition of the baby. The constipation persisted until about two weeks prior to the last admission when the child began to develop diarrhea.

Three days prior to admission we come to the final illness. The child became considerably distended and he appeared to have abdominal pain. With this there were lethargy, refusal of feedings, listlessness, and then on the day of admission he began to have projectile vomiting, with bile or at least green vomitus which smelled like bile. He weighed 14 lb. 11 oz., not more than a 3 lb. gain in the three months, so that the weight gain was not particularly good but not strikingly bad. The baby's temperature was 103.6°, pulse 144, the respirations not particularly increased. He was given supportive care and neomycin. His temperature then went up to 104.8°. He had a convulsion involving mostly the right leg. He was given Amytal and saline and the convulsion stopped. At this time a barium enema was performed and he was also seen by surgical consultants, who suggested that a colostomy be done. We have no further description of the final episode until he died.

I have quite a great deal of difficulty in deciding whether this was primarily an irritative phenomenon which was manifesting itself during the first three months as diarrhea, or a constipation problem which became more prominent during the second three months. My tendency is to go more to the constipation problem as the more significant part of the history. Diarrhea occurs in a number of illnesses. The majority are of the infectious type, occurring as a result of a wide variety of infectious agents. You can get chronic diarrheas in allergy, such as allergy

to cow's milk. Fibrocystic disease can produce diarrhea at this age. There are other diarrheas of an irritative type. For instance, we have diarrhea secondary to antibiotics, those secondary to ulcerative colitis and with diverticulitis. You can get diarrhea associated with megacolon. Actually this is not diarrhea but results from stool coming past an obstructed lower bowel. A few others sometimes present as diarrhea such as adrenal hyperplasia. Regional enteritis can appear as a diarrhea, and a few other rare ones.

When we look back on this history and see that in the second admission there was a distended abdomen, we might start thinking of obstructive phenomena due perhaps to a malrotation. With duplication of the bowel you usually have melena, which was not mentioned in this history. The problem then became one of chronic constipation. We should think of something that might occur to cause this chronic constipation, perhaps some type of stricture at the rectal area, but we have no evidence for this since the baby had had good stools for a while. Megacolon can show a picture of chronic constipation exactly as this child did, and it can present with intermittent episodes of diarrhea around the obstructed stool, with poor weight gain.

The final episode could be due to rupture of some part of the bowel with resulting high fever and marked vomiting. I still worry about the initial diarrhea and the fact that the baby was having yellow stools—without blood or mucus. I think the final episode fits the pattern of an obstructed aganglionic megacolon. We have some final barium enemas which will probably give us the diagnosis.

DR. HOWARD: On the first admission the child did have films taken that could have given a clue that was there and missed. The last study did show that the patient had Hirschsprung's disease with definite caliber change of his rectal area. Of great interest is the severe ragged appearance of the mucosal pattern of the descending colon which to us indicates that the baby probably had a rather severe colitis along with this enteritis.

#### CLINICAL DIAGNOSIS

1. Aganglionic megacolon (Hirschsprung's disease).
2. Terminal rupture of bowel.

#### PATHOLOGIC DIAGNOSIS

1. Congenital aganglionic megacolon (Hirschsprung's disease).
2. Pseudomembranous enterocolitis, severe.
3. Focal necrotizing pneumonitis.
4. Focal renal necrosis.

#### DISCUSSION OF PATHOLOGY

DR. NEWTON: The findings at autopsy have been well predicted by Dr. Robbins. The child did have



congenital aganglionic megacolon with several unusual complications.

On opening the abdomen, the colon was obviously enlarged and the wall thickened, but there was no evidence of perforation. There was generalized enlargement of the colon with some induration of the distal small intestine. The distal rectosigmoid showed no obvious sharp constriction or diminution in caliber as is seen in most instances of congenital megacolon. The mucosa of the entire large bowel and distal small bowel had a thick, yellowish-white pseudomembranous coating with scattered foci of mucosal ulceration not covered by this material.

Microscopic sections were taken from the rectal area through the entire length of the bowel at 3 cm. intervals. Sympathetic ganglion cells were found absent in the distal 15 cm. of the large bowel but present elsewhere. It therefore appears that this child had aganglionic megacolon of a small segment of the rectosigmoid which did not produce the funnel constriction usually seen in these patients. In addition there was this reactive change on the mucosal surface of the colon and distal small intestine. Microscopically, the mucosal pattern was distorted with severe subacute and acute inflammatory changes with necrosis of the upper layers forming a pseudomembrane. Attempts at culturing an organism were not fruitful. I have reason to suspect that this might have been related to a *Pseudomonas* species on the basis of some changes that we will present shortly, namely, changes in the lung and kidney.

Although the lung and kidney did not show any striking changes grossly, there were focal areas of necrotizing infection surrounding small arterioles showing partial obstruction and acute necrotizing arteriolitis. This picture pathologically has been observed in instances of gram-negative bacterial sepsis, particularly related to the *Pseudomonas* species. We were not able to recover an organism from the blood, peritoneal cavity, or bowel content.

To sum up this pathologic picture briefly, it would appear that this child had chronic intestinal obstruction of relatively severe proportions due to absence of the sympathetic ganglion cells in the distal 15 cm. of his bowel with a terminal event of pseudomembranous enterocolitis, septicemia, and necrotizing inflammation of the lung and kidney. Dr. Kottmeier has been interested in this problem and has recently reviewed our clinical experience. Would you like to comment, Dr. Kottmeier?

DR. KOTTMEIER: We recently reviewed our cases over the past seven years and found a total of 56; of these 19 must be classified as ganglionic and 37 as aganglionic megacolon. As is true in other studies, there was a male predominance. The ratio of Negro to white patients corresponded to the general admission rate for the hospital.

Ganglionic megacolon has been divided into four

groups by others: psychogenic; those seen in mentally defective children; those associated with anal obstruction; and lastly, congenital cretins. Psychogenic megacolon usually occurs between the first and third years of life, and the barium enema in those children shows the ampulla to be dilated. In the cases with mental retardation there is no demonstrable narrowed segment of colon. We have seen only an occasional instance of organic anal obstruction. Simple anoplasty is used to treat this group. An example of this is an instance of a 4 year old boy who had chronic constipation because of an imperforate anus treated in the newborn period. We have not seen any children with cretinism and constipation.

It would seem likely that the age of onset of symptoms would help in differentiating the ganglionic from the aganglionic types of megacolon. As one would expect, all our patients who lacked ganglion cells in their distal colon showed the onset of symptoms in the first year of life, but about three fourths of those with ganglion cells likewise showed symptoms before the age of 1 year. Indeed, two thirds of these had symptoms in the first week of life. The symptomatology of both groups included abdominal distention, vomiting, abdominal pain, and obstipation. So neither the time of onset nor the symptoms themselves differed clearly in those groups with and without ganglion cells. Rectal biopsy is the method of choice for making this differentiation, if the specimen is satisfactory and the pathologist experienced.

DR. NEWTON: Dr. Morse, do you have any comments?

DR. MORSE: When a child comes in with enteritis any time after the first week of life, the baby with Hirschsprung's disease will have a history of abnormal bowel function dating back to birth. The smaller the child the more difficult the diagnosis becomes on barium enema, particularly in the newborn period. To get an adequate rectal biopsy, the two layers of muscle in the colon wall must be included. This is a formal operation that has to be done under general anesthesia. It would not be worth while if there were false negatives. Its validity is based on the assumption that if ganglion cells are absent anywhere in the gastrointestinal tract they will be absent in the rectum. Dr. Swenson once told me that he had seen one false negative out of 150 biopsies.

DR. NEWTON: From my own experience, tissue from the rectal area is more difficult to interpret than tissue from the bowel elsewhere taken at the time of colostomy and presents real problems to the inexperienced pathologist who is asked to make a frozen section diagnosis as to the presence or absence of ganglion cells.



# NEWS AND *Organization Section*

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## AMA Clinical Convention ...

Summary of Actions Taken by the House of Delegates  
At Miami Meeting; Ohio's Official Delegation, etc.

HEALTH care for the aging, a new teletype communications system for the medical profession, a statement on human reproduction and recommendations from the Commission on the Cost of Medical Care were among the major subjects acted upon by the House of Delegates at the American Medical Association's 19th Clinical Convention held November 29 - December 2 in Miami Beach, Florida.

Tribute was paid to the late Dr. Norman A. Welch, AMA President who died on September 3, in a memorial statement from the Massachusetts Medical Society and in a resolution adopted by the House.

Dr. James Z. Appel of Lancaster, Pa., vice chairman of the AMA Board of Trustees and a member of the Board since 1957, was named President-Elect of the Association. He will become President in June, 1965, succeeding Dr. Donovan F. Ward of Dubuque, Iowa, who took office after the death of Dr. Welch.

To take Dr. Appel's place on the AMA Board of Trustees, the House elected Dr. Joseph B. Copeland of Austin, Texas, who for the past year has been serving as Deputy Commissioner of Health in the State of Texas.

Final registration at the convention reached a total of 9,356, including 4,118 physicians.

### Ohio Delegation

The Ohio State Medical Association was represented in the AMA House of Delegates by the fol-

lowing persons: Dr. George W. Petznick, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. Theodore L. Light, Dayton; Dr. Edmond K. Yantes, Wilmington; Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Paul F. Orr, Perrysburg; Dr. Charles A. Sebastian, Cincinnati; and Dr. Edwin H. Artman, Chillicothe.

Also attending the meeting as alternate delegates were: Dr. Horatio T. Pease, Wadsworth, also Immediate Past-President of OSMA; Dr. Robert S. Martin, Zanesville; Dr. Kenneth D. Arn, Dayton; Dr. Harry K. Hines, Cincinnati; Dr. P. John Robeche, Cleveland; Dr. Robert E. Tschantz, Canton, also OSMA President; Dr. Frederick P. Osgood, Toledo; and Dr. J. Robert Hudson, Cincinnati.

Also present at the meeting and attending meetings of the House of Delegates were Dr. Henry A. Crawford, Cleveland, President-Elect of OSMA; Dr. Robert E. Howard, Cincinnati, Councilor of the First District; Hart F. Page, OSMA director of public relations and assistant executive secretary; and Herbert E. Gillen, of the OSMA staff.

Dr. Perry R. Ayres, Columbus, editor of *The Journal*, attended a meeting in his capacity as a member of the board of directors of the State Medical Journal Advertising Bureau, the national advertising representative of *The Journal*, and other state medical journals. He also attended AMA meetings.

Mrs. William H. Evans, Youngstown, President, of



the Woman's Auxiliary to the AMA, addressed the House of Delegates in behalf of the Auxiliary.

### House Reference Committees

Several Ohioans served on Reference Committees of the House of Delegates.

Dr. Carl A. Lincke served on the Reference Committee on Reports of the Board of Trustees.

Dr. Theodore L. Light served on the Committee on Insurance and Medical Service.

Dr. Charles A. Sebastian served on the Committee on Rules and Order of Business.

### Committees and Councils

Among Ohioans who are serving on AMA Committees and Councils are the following:

Dr. Robert S. Green, Cincinnati, Committee on Federal Medical Services. Dr. George J. Hamwi, Columbus, Council on Foods and Nutrition.

Dr. F. A. Simeone, Cleveland, Council on Drugs.

Dr. Fay A. LeFevre, Cleveland, Council on Post-graduate Programs.

Dr. Edmond K. Yantes, Wilmington, Council on Rural Health.

Dr. John R. Haserick, Cleveland, Committee on Cutaneous Health and Cosmetics.

Dr. Paul L. Weygandt, Akron, Committee on Medical Aspects of Automotive Safety.

Dr. Thomas E. Shaffer, Columbus, Committee on Medical Aspects of Sports.

Dr. George W. Petznick, Cleveland, Committee on Medicine and Religion.

Dr. Dwight M. Palmer and Dr. James V. Carren, both of Columbus, Committee on Rating of Mental and Physical Impairment.

### Board of Trustees

Dr. Charles L. Hudson, Cleveland, attended sessions of the House of Delegates as a member of the AMA Board of Trustees.

### Ohio Resolution Approved

The AMA House of Delegates approved a resolution presented by the Ohio delegation to modify the procedure for seating of delegates and alternates. In effect the proposal would insure that each state may have its full quota of delegates by the seating of alternates when the designated delegate or his designated alternate is unable to attend sessions. The resolution was referred to the Council on Constitution and Bylaws for study and report back at the next session of the House of Delegates.

### Health Care for the Aging

Definitive action on the issue of health care for the aging came with the House of Delegates' strong endorsement of Dr. Ward's Monday address, in which he declared that "We have no choice except to

stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

Reaffirming the Association's opposition to the King-Anderson type of legislation, Dr. Ward said:

"If we have been right in the past — and that is our unshakeable belief — then we are right today. And we shall be right tomorrow."

Calling for renewed, intensive effort to prevent the passage of such legislation, he pointed out that "we do not, by profession, compromise in matters of life and death. Nor can we compromise with honor and duty."

Dr. Ward, expressing pride in the medical profession, concluded his address with these statements:

"I pray that we all gain strength for renewed effort by the simple reflection that what we are doing is worthwhile — that if the effort is great, the results of not making the effort would be unthinkable — and, finally, what we are doing is vastly more important than ourselves.

"No more can be asked of us as citizens. No less should be offered by us in guarding our heritage of freedom."

### Action of the House

To implement the ideas in Dr. Ward's address, the House gave unequivocal approval of a Board of Trustees suggestion that an expanded educational program be conducted in the next few months. In asking for this approval, the Board pointed out that "a variety of techniques and media must be utilized if the public, the Congress and special audiences are to be reached effectively."

The House took no action on three resolutions which would have altered the AMA position on health care legislation. Instead, the House adopted a resolution which urged "component associations to stimulate the state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care will be available."

The state medical societies also were urged to send representatives to two conferences related to the issue of health for the aging — one of the conferences was held on December 13 to help plan the new educational program, and the other is scheduled on January 9-10, to consider further implementation and expansion of the Kerr-Mills programs.

### Teletype Communications System

The House approved a recommendation from the Board of Trustees for establishment of a teletypewriter communications service between the AMA and the state medical societies. The system will provide automatic and uninterrupted communications



between AMA Headquarters and all participating state societies, and between the state societies without involving the facilities at the AMA Headquarters. The system also will enable any state society to communicate with all other TWX subscribers in the United States and Canada.

In approving the recommendation, the House emphasized that participation is optional with the state medical societies but it also urged each society to "seriously consider taking advantage of this rapid communications system." Installation and rental costs for the teletype equipment, both at AMA Headquarters and at the headquarters of each participating medical society, will be paid by the AMA. The cost of transmitting messages will be paid by whichever organization originates each message. Hope was expressed that the new communications system would become operative no later than July 1965.

### Human Reproduction

Updating its policies on population control, "to conform to changes in society and medicine" and to "take a more positive position on this very important medical-socio-economic problem," the House adopted the following four-point statement:

"1. An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

"2. The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.

"3. In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"4. The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

In taking the action, the House also recommended that the AMA cooperate with the appropriate voluntary organizations in the field of human reproduction which have adequate medical direction.

### Commission on the Cost of Medical Care

With modifications suggested by the Board of Trustees, the House approved 33 recommendations from the Commission on the Cost of Medical Care. The suggestions had been rearranged by the Board into four sections—Research, Hospitals, Physicians and Miscellaneous. In accepting the Board report, the House also rejected a floor amendment which recommended that a medical advisory committee composed of practicing physicians be appointed to supervise the several studies which were suggested.

In presenting its conclusions and recommendations

to the Board of Trustees, the Commission on the Cost of Medical Care expressed the hope "that the recommendations which are approved will help promote the wisest possible use of the medical care dollar and aid in the development of more meaningful data on the cost of medical care."

The House learned that a substantial number of the studies recommended by the Commission are already under way and that others are in the process of being implemented. The House also emphasized its appreciation of the importance of these continuing studies and urged that adequate funds be provided for maximum implementation of the recommendations.

### Miscellaneous Actions

In considering a wide variety of annual reports, special and supplementary reports and resolutions, the House also:

Amended the Bylaws to permit the presidential inauguration to take place at a time other than Tuesday evening and approved a suggestion that the inaugural ceremony at the 1965 Annual Convention be held on Sunday, June 20;

Amended the Bylaws to permit presentation of the AMA Distinguished Service Award at a time to be determined by the Board of Trustees and learned that the Board wishes to present this award at the Scientific Awards Dinner;

Agreed that the AMA should cooperate with the U. S. Public Health Service in eradicating the *Aedes aegypti* mosquito from the American hemisphere;

Urged strong support of the Woman's Auxiliary and asked the state and county medical societies to give serious consideration to the idea of joint husband-wife membership;

Agreed that a section on Space Medicine should not be created at this time;

Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, nondeductible contribution to independent political action committees on the society's annual dues billing statement;

Approved a Board recommendation that the 1967 Clinical Convention be held in Houston, Texas;

Agreed with the Board that there should not be an increase in AMA dues at this time;

Reaffirmed its approval and support of the National Council for Accreditation of Nursing Homes and

Instructed the Board to re-evaluate the mission of the Commission on Medical Practice and take appropriate action.

The American Medical Association Education and Research Foundation reported to the House that one out of every six medical students, interns and resi-

dents in the U. S. is now receiving financial assistance from the Foundation's loan fund. The AMA-ERF also announced that Merck Sharp & Dohme pharmaceutical company has made its fourth \$100,000 contribution to the loan fund and has pledged an additional \$100,000 in 1966.

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## Ohioans on Scientific Program At AMA Miami Convention

Ohio was well represented by physicians who spoke during scientific sessions at the Miami Convention of the AMA, or otherwise participated in the program; also by the number of physicians or teams from Ohio represented in the Scientific Exhibit.

Following are Ohioans who participated as indicated in the official program printed in the October 26 issue of *The Journal of the AMA*:

Dr. Walter A. Hoyt, Jr., Akron, discussed the "Etiology of Contact Injuries," in a Symposium on the Shoulder in Sports, a part of the Sixth National Conference on Medical Aspects of Sports.

Dr. Thomas E. Shaffer, Columbus, was moderator of a discussion group section on "Sports for the Teenager," part of the Conference on Medical Aspects of Sports.

Dr. Robert J. Murphy and Dr. William F. Ashe, Columbus, spoke on "Sports and Climactic Conditions," during the Conference on Medical Aspects of Sports.

Dr. Jay L. Ankeney and Dr. Earle B. Kay, Cleveland, participated in the Fireside Conferences sponsored by the American College of Chest Physicians, in the roundtable discussion entitled, "Prosthetic Cardiac Valves."

Dr. Henry A. Zimmerman, Cleveland, another Fireside Conference participant, was in the roundtable discussion entitled "Cardiac Catheterization Techniques."

Dr. Howard S. Van Ordstrand, Cleveland, was moderator for the discussion on "Pulmonary Fungus Diseases," a part of the Fireside Conferences.

Dr. Charles L. Hudson, Cleveland, spoke on the topic, "Responsibility of the Private Physician in Eradication of Syphilis," in the Public Health program.

Dr. Douglas Goldman, Cincinnati, discussed the topic "Clinical Diagnosis of Depressive States," in a program on Depressive States.

Dr. Charles H. Brown and Dr. Thomas F. Nikolai, Cleveland, were principals in a motion picture entitled "Percutaneous Liver Biopsy with Vim-Silverman and Menghini Needles."

Dr. Frank F. A. Rawling, Toledo, spoke on the subject of "Planning for an Urban Community," in the First National Conference on Areawide Health Facilities Planning held in Miami Beach on November 28 - 29.

Dr. William R. Schultz, Wooster, chairman of the OSMA Committee on Hospital Relations, attended

## What Feature in The Journal Do You Like Best?

That is one question in the quiz on the last page of this issue of *The Journal*. Please take a minute or two to jot down your opinions. Then mail the questionnaire post card to *The Journal* and help the staff produce a better publication.

the First Conference on Areawide Health Facilities Planning held on the eve of the AMA meeting.

## Scientific Exhibit

Dr. Ralph G. Carothers, Cincinnati, was chairman emeritus of the Special Exhibit on Fractures.

Dr. R. T. Gallagher and Dr. John C. Schmerge, both of Cincinnati, were demonstrators in the Special Exhibit on Fractures.

Dr. John H. Kennedy and Dr. Nicholas Bailas, Western Reserve University School of Medicine and Cleveland Metropolitan General Hospital, Cleveland, presented an exhibit entitled, "Mechanical Support of the Failing Heart," in the section on Cardiopulmonary Topics.

Dr. Richard B. Stoughton and Dr. A. W. McKenzie, Western Reserve University, Cleveland, presented an exhibit entitled, "Bio-assay of Steroids for Topical Application," in the General Practice section.

Dr. Robert E. Hermann and Dr. Stanley O. Hoerr, Cleveland Clinic Foundation, presented an exhibit on the subject, "Operative Cholangiography — The Case for Its Routine Use," in the Radiology section. This same exhibit won the bronze award in the teaching field at the 1964 Annual Meeting of the Ohio State Medical Association.

Dr. Ralph B. Samson and Dr. C. O. Andarsio, Grant and Mt. Carmel Hospitals, Columbus, presented an exhibit entitled "Villous Adenoma" in the Section on Gastroenterology.

The Akron City Hospital team consisting of Dr. William H. Falor, Dr. William V. Sharp and Dr. Earle Le Vernois, presented the exhibit, "Which Scalene Lymph Node Would You Excise?" in the Surgery section. This exhibit won the silver award in the teaching field at the 1964 OSMA Annual Meeting in Columbus.

Dr. Chester C. Winter, Ohio State University, Columbus, presented an exhibit entitled, "Correctable Renal Hypertension," in the section on Urology. This exhibit also was presented at the 1964 OSMA Annual Meeting in Columbus.

An Ohio State University Hospital team presented the exhibit, "An Aid in the Postoperative Management of Cystocele Repair," in the section on Urology. The team consisted of Dr. Martin E. Felder, Dr. Richard P. Dickey and Dr. William Copeland.



# What Is the Job of the Individual In a Mass Medical Emergency?

SOME 425 people attended a Conference on Disaster Medical Care in Columbus, October 18, 1964, where they heard on-the-scene reports of a number of local disasters and received instructions on the role of the individual under similar circumstances.

Dr. Robert E. Tschantz, President of the Ohio State Medical Association, presided over the meeting which was cosponsored by OSMA and the Ohio Hospital Association, The Ohio Department of Health, Ohio Civil Defense and The American Red Cross. Of the 425 registrants, 125 were physicians.

The Conference was designed to answer the question, What Is Your Job in a Mass Medical Emergency? To accomplish this, the speakers explored the roles of the health professions in relation to several recent natural disasters. These included the Indianapolis Coliseum Icecapades explosion, the Alaskan Earthquake, the Fitchville, Ohio Nursing Home Fire, the Toledo Airplane Crash and the Ohio Valley Flood. In addition, a report was made on current federal government planning and the importance and effectiveness of the testing of community and hospital disaster plans was explored.

A summarization of the presentations at the Conference as well as some editorial comments and conclusions by Dr. Francis C. Jackson, chairman, Committee on Disaster Medical Care, American Medical Association, are provided below.

\* \* \*

## Division of Health Mobilization And What Is Being Planned

Arnold Dodge, acting chief of the Division of Health Mobilization of the U.S. Public Health Service, provided a comprehensive summary of current programming in this agency, particularly as it evolved from a recent divisional workshop held in Dallas, Texas.

He indicated that there is a definite reprogramming with an emphasis on improving emergency service capability in terms of natural disasters. He indicated that high population density, increase in intercity movement, together with the increasing susceptibility of high impact involvement of population by weather, aircraft, flammable materials, etc. creates an ideal environment for natural disaster. He emphasized that it was the obligation of the health professions to plan satisfactorily for these problems and he admitted that there had been a certain short-

sightedness in terms of natural disaster planning within a number of the Federal agencies. Much of the program had in the past evolved from World War II models of planning for Civil Defense disasters and many people were denied medical supplies and equipment during natural disasters because of this rigid requirement.

He outlined some of the history of the Division of Health Mobilization indicating its birth in 1959 and its assumption of the medical stockpiling program in 1961. It is now responsible for \$239,000,000 worth of stored medical supplies, principally in the form of the 200 bed Civil Defense emergency hospital. Two thousand of these are prepositioned and some 750 new units are currently coming off the production lines.

Mr. Dodge then proceeded to outline in some detail the current thinking of the Division of Health Mobilization.

a. The new hospitals will probably be called "emergency hospitals," avoiding the words "Civil Defense." They will contain "in and out increments" for training purposes rather than entire units being assigned as "trainers." Replenishment will be provided following an annual inspection.

b. Training centers for the use of these hospitals will be established throughout the country, primarily with the help of the state and local medical societies and under the supervision of the state and county health departments, and Offices of Civil Defense.

c. The emergency hospitals will be incorporated with "sub-assemblies" so that they may be quickly dispatched to scenes of disaster.

d. In the planning and drawing board stage, are 25, 50 and 100 bed hospitals which will be used as portable units in terms of natural disaster requirements.

e. The medical self-help program is being extensively publicized by the use of professional promotional programs, such as the Danny Thomas television program released last November.

f. Table top training models are being developed for staff training exercises in space utilization in varying sizes of buildings which could house the emergency hospital units.

g. The Health Mobilization pamphlet services continues to provide useful information. Two recently printed ones are: A-1, entitled "Emergency



Health Preparedness Publication Catalogue" and A-2, "Community Emergency Health Preparedness" which are available from the U. S. Public Health Service (Department of Health, Education and Welfare).

Lastly, Mr. Dodge outlined the recent use of a complete 200 Civil Defense emergency hospital in Louisiana during Hurricane Hilda. The unit was set up near Richland. Twenty-one people died in this disaster and there were 160 injured. A complete inventory and report on the use of this hospital by Division of Health Mobilization is currently in progress.

Probably the important information provided by Mr. Dodge, however, was the recognition by Federal agencies of the "parallel job of Civil Defense" in terms of natural disasters. He indicated that there may still be certain administrative difficulties with Congress, and the U. S. Comptroller General regarding use of funds for this purpose, but that he felt the program was sound and would probably receive satisfactory support.

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### **Lessons Learned from Disaster Of Toledo Airplane Crash**

John E. Strawbridge, administrator of Maumee Valley Hospital, Toledo, proceeded to review details of the airplane crash disaster on the night of October 29, 1960, in sequential order. This was a charter flight of "Artic-Pacific" Airlines carrying the football team of California Polytechnical Institute from Toledo to the Coast. He indicated that visibility at the airport was zero with a particularly heavy fog. The airplane contained 45 passengers with a crew of three. The pilot walked the entire length of the runway before the attempted take-off in order to examine the conditions, particularly with reference to the border light which were only partially visible. The airplane was the only one in the airport area at the time and could not be seen by the control tower. It proceeded down the runway, and obtained an altitude of 100 feet before it crashed 5,800 feet from the threshold of the runway.

The attempted take-off was at approximately 10:00 p. m. The sheriff's office was notified of the accident at approximately 10:45 p. m. Immediate rescue efforts were hampered by the distance from the city hospitals (five or six miles), and the heavy fog.

Twenty-two of the passengers and the entire crew were killed and 16 survived the immediate crash. No medical authority was established at the airport, ambulances were uncontrolled. The drivers frequently proceeded to the farthest hospital "because the others were going to the nearest." While the security and command at the airport was in the hands of the State Highway Patrols, the weather prevented their immediate arrival. It was Mr. Strawbridge's feeling that two who died might have survived if they had been taken to the nearest hospital.

While the airport had a disaster plan, it did not have a medical annex and no physicians were called. One hospital which had a total of 45 beds available, three senior M. D.'s, seven resident surgeons, and three medical residents on duty, received only three survivors.

Following a restudy of the disaster, several recommendations were made to the city of Toledo officials as follows:

1. The standards for ambulance drivers should be placed in the city code and enforced.
2. Two-way radios should be established between hospitals and ambulances.
3. Hospitals should always have advanced warnings of disasters.
4. Ambulance personnel should be relieved of the responsibility of sorting survivors among the hospitals.
5. One of the central agencies in the city (police, fire department, or health department) should be informed daily of the available beds among the respective community hospitals.

### **The Role of Toledo Hospital**

Wilson L. Benfer, administrator of the Toledo Hospital, outlined the role of the Toledo Hospital which received a total of 13 survivors. The airport disaster represented the first test and use of this hospital's disaster plan.

Fortunately the disaster occurred at the change of the evening shift. The supervising nurse, therefore, was able to hold all nurses from two shifts upon the arrival of the casualties. While the hospital had emergency medical teams and other volunteers available, these were not called to the disaster site. There was considerable immediate congestion in the Emergency Room. However, this was gradually overcome as the patients were sorted and cared for.

Mr. Benfer felt that there were two principal weaknesses in their disaster plans; (1) only professional employees had been notified and administrative, maintenance, and other personnel who could have assisted were delayed in their arrival at the hospital; and (2) the delay in the identification of patients.

The hospital was unable to provide information for relatives and others regarding either the names of the survivors or the dead. He suggested that hospitals should be notified by the coroner of all deaths at the disaster scene in order to maintain a complete inventory.

After conferences among police, Red Cross, medical societies, etc., all hospitals now have short-wave receivers and communications are improved.

Mr. Benfer went on to emphasize that the primary stimulus for hospitals to develop disaster plans was that such documents were required by the Joint Commission on Hospital Accreditation. He stressed the importance of testing or rehearsing. In one drill,

it was quickly demonstrated that there were no supplies assigned to one reception area. He made reference to an article entitled, "How Well Are Hospitals Prepared for Mass Disaster?" by Engelmohr, J. H., in *Hospitals*, 37:35-37, June 1, 1963.

#### **Role of the American Red Cross**

Carleton Rae, executive director of the Greater Toledo Area Chapter, American Red Cross, reported that the Red Cross provided two feeding stations at the airport, supplied fifty units of blood, and 12 units of serum albumin, all of which were used. In addition, mobile emergency teams were sent to the airport, although they did not arrive until after many of the patients had been transferred. One of the problems these Red Cross teams faced was the clogging of roads to the airport caused by heavy fog and crowds of the curious.

The principal job which the Red Cross performed was in locating survivors and providing information and assistance to the families of both the surviving and deceased passengers. Through the Red Cross Chapter in San Luis Obispo regular reports on the progress of the survivors was provided to the California Polytechnical Institute and the families. Five months after the accident, the last casualty left the hospital accompanied by a Red Cross nurse to California.

Mr. Rae emphasized Red Cross provides first aid teams or zone mobile teams and communication facilities for assistance at disaster sites. In addition, training courses are provided for ambulance drivers. He emphasized the effectiveness of the disaster in developing plans and preparations utilizing the welfare and other services of the Red Cross.

#### **Role of the Health Commissioner**

Hilbert Mark, M.D., M.P.H., health commissioner of Toledo, emphasized that while the Health Department has a role to play in disasters, his department unfortunately, through oversight, was not invited to participate in the "post-crash" reorganization in Toledo.

He indicated that Public Health nurses, sanitarians, epidemiologists and others with semi-medical skills can provide a considerable team effort to meet the problems of many disasters. In terms of medical emergencies, they function subordinate to hospitals, the Offices of Civil Defense, and medical administrators. He outlined the extensive programming and role in which public health officials plan to participate in terms of national disasters including the problems of biochemical and thermonuclear warfare.

\* \* \*

#### **Health Experiences Coming Out Of the Ohio Valley Flood**

Aileen L. MacKenzie, M.D., acting chief of the Division of Chronic Diseases, Ohio Department of Health, Columbus, provided an excellent panoramic picture of the Ohio Valley Flood which struck Mari-

etta, Ohio, in the Spring of 1964. She reviewed the mechanisms of flooding and emphasized the need for constant monitoring and evaluation of the rising waters. One of the most difficult problems was the reluctance of people to leave their homes. In this instance, the Red Cross office acted as a central information center shelter. Facilities were provided for over 100 refugees.

While there was no loss of lives and many roads were blocked, isolating the community for a period, it continued to function exceedingly well. The only problem faced was that of the contamination of the city water supply. However, the economic impact was great. Recovery nevertheless was prompt and effective as the subsiding of water. The important factor in this community disaster was its past experience with the problems of flooding. The "citizens knew what to do."

\* \* \*

#### **Fitchville Nursing Home Fire And Emergency Actions**

Thomas L. Hooper, Jr., field representative-at-large, Eastern Area of the American Red Cross, Alexandria, Virginia, described the Fitchville Nursing Home fire in Huron County and his personal role. Upon learning of this tragic episode, he notified the Red Cross representative in the local county, as well as the Toledo Nursing Service and its Blood Center. First aid emergency teams were ordered to Fitchville from as far away as 22 miles. However, they were not required.

There were 63 patients who died in the fire and 21 survivors, of whom 16 were promptly released from the hospital.

The Red Cross assisted in the identification of the dead, and locating the relatives of the deceased as well as living. In addition, food, transportation, and communication services were provided for officials and relatives alike.

\* \* \*

#### **Disaster Plan Testing In Cleveland Area**

Roger W. Marquand, administrator, Polyclinic Hospital, Cleveland, reviewed the background and history of "Operation Know-How" which is an annual community disaster rehearsal supported and directed by the Disaster Relief Committee of the Cleveland Academy of Medicine as well as the Cleveland Office of Civil Defense.

He emphasized that hospital disaster plans are worthless unless they are rehearsed, evaluated, and redesigned. The use of simulated casualties, a variety of transporting via transport vehicles, and military units, provided stimulus and experience in the management of large numbers of injured (over 1,000 in the past recent drill). In the last exercise in 1963, the 200 bed Civil Defense emergency hospital was erected in the Sheraton Hotel and casualties were re-



ceived and processed as a public demonstration of this unit.

In general, Mr. Marquand felt that the results of these rehearsals have been good, particularly in pointing out certain deficiencies. The inadequate admitting facilities of some hospitals, the need for command post staffing, effective communications (both intra-hospital and extra-hospital), record keeping, and traffic control. He felt that it was worthwhile and important for hospitals and agencies to continue to practice their jobs in terms of their disaster plans.

\* \* \*

### **Alaskan Earthquake Disaster Many Phases of Relief**

Edward R. Menders, director of disaster services for the Franklin County Chapter of the American Red Cross emphasized that the Alaskan Earthquake was primarily a disaster in terms of tremendous welfare need. The medical requirements were limited. Eighty-two Alaskans are known dead, and 33 are presumed dead. There were 700 injured, of which 653 were minor. There were 77 major injuries and 114 survivors were hospitalized. Essentially, there was no need for emergency hospitals in this earthquake since the major hospitals in Anchorage and elsewhere were able to function effectively.

He emphasized that Red Cross is still able to mobilize an excellent organization and provide relief funding. To date, \$1,150,000 has been spent in Alaska by the Red Cross.

During the disaster, the Red Cross units were able to issue daily casualty lists, provide nursing and first aid services in the various temporary shelters and to transport relatives. The Red Cross is currently engaged in a rebuilding program for survivors, particularly in the Valdez and Seward areas.

#### **Disaster Research Center**

Daniel Yutzy, research associate in the Disaster Research Center, Ohio State University, Columbus, reported that the OSU center had reviewed and studied 17 disasters in the past year, primarily examining the functioning of social and community organizations such as police, fire departments and the Red Cross as they responded to the extreme stress upon their emergency services.

In reporting on the Alaskan Earthquake, he indicated that he reported on the experiences of a small and large hospital (Hospitals A and B) in Anchorage. In the small (Hospital A) there was a census of 50 patients and a staff of 58 physicians. Most of the staff were not present in the hospital. Following the tremors, all power was lost and an odor of gas was detected throughout the lower floor. The supervising nurse immediately wrote "No Smoking" with her lipstick on all outside doors. The major quake occurred at 5:30 p.m. and because of the conditions of the hospital, all patients were transferred by 7:00 p.m. to Hospital B. However, after

60 hours, a return of full services in the hospital was effected.

Hospital "B" had 56 patients with 100 empty beds. There were 57 doctors on the staff. All of the admitting staff were absent. Although power was lost, an emergency unit was promptly activated and supplied emergency services. The architect of the hospital reported to the building immediately, and after inspecting it claimed that there was no major structural damage and that the hospital could function. One of the physicians acted as a disaster coordinator, and promptly assigned personnel and doctors who were available to various duties. Four physicians manned the emergency room.

The nursing staff was augmented from Hospital "A." However, there were only 21 casualties treated in the first few hours, three of which were dead on arrival's. Only seven were admitted the first night and eight later. The hospital census never exceeded 123. Throughout the entire earthquake period between 250 and 300 survivors and injured were treated in the Anchorage area for major and minor injuries.

The major problems of the earthquake were loss of communications, water, power, and the problems created by the convergence or at the hospitals. Here, problems created by the loss of utilities, the necessity for quickly organizing the medical and supporting staff, and the lack of information on casualties admitted were all finally overcome.

Mr. Yutzy suggested that since the earthquake occurred late in the afternoon and with the weather relatively mild for that time of the year (temperature in the low 20's) the number of injuries was limited despite the devastating extent of the earthquake itself.

#### **Alert by Radio Operator**

Gleason O. Seaman, Jr., chief of the Editorial Programs Branch, Office of Civil Defense in Washington, D. C., emphasized that Alaskans are vigorous people and he recounted several anecdotes regarding their toughness. He reported that the real hero at the Anchorage Hospital was a RACES (radio amateur communication emergency system) radio operator who provided effective, early communications through to the Office of Civil Defense. He indicated that the public Health operations were primarily devoted to water supply and inoculation in the preventions of epidemics. He made an interesting observation that several psychotic or disturbed patients seemed to be normalized by the earthquake. However, there were no outbreaks of acute infectious diseases.

\* \* \*

*(To Be Continued in February Issue)*

Reports on the Iccapades Disaster at Indianapolis Coliseum, presented from four different standpoints, will be a feature of next month's continuation of this summation. Also included will be some concluding remarks by the author of this report.

# Annual Meeting Highlight...

## Heart Program: "Drug Therapy of Cardiac Disease," A Feature of OSMA Meeting in Columbus, May 9-14

**A** GAIN this year, the Ohio State Heart Association will sponsor a General Session at the 1965 OSMA Annual Meeting, scheduled in Columbus the week of May 9-14. The Heart program will be on Thursday morning, May 13, the General Session theme being, "Drug Therapy of Cardiac Disease."

With a theme of interest to physicians in all branches of practice, the Heart Association has invited top men in the field to present their program. Following are topics and speakers:

### "Drug Therapy of Cardiac Disease"

Moderator: George Morrice, Jr., M. D., Columbus.

Management of Shock of Acute Myocardial Infarction, Phillip Horowitz, M. D., Toledo, associate staff, Toledo Hospital.

Coronary Vasodilators, George G. Rowe, M. D., Madison, professor of medicine, Cardiovascular Section, University of Wisconsin Medical Center.

Rationale and Proper Use of Digitalis, (The Rudolph Allen Gerlinger Memorial Lecture of the Northwestern Ohio Heart Association), Paul N. Yu, M. D., Rochester, N. Y., professor of medicine and chief of Cardiopulmonary Unit, School of Medicine and Dentistry, University of Rochester.

Digitalis Toxicity, Joseph M. Ryan, M. D., Columbus, professor of medicine, and chief of Heart Station, Ohio State University College of Medicine.

(Question and answer period after each presentation.)

### Other Annual Meeting Features

A number of other specialty groups are presenting programs of interest to their particular field, but also of value to physicians in all branches of practice. All physicians are welcome to attend all programs at the Annual Meeting, regardless of branch of practice.

On Monday afternoon, May 10, the Ohio State Surgical Association will present a program, details of which will be announced in the near future. The afternoon scientific session will be followed by a social hour and dinner.

On Tuesday afternoon, the Ohio Committee on Trauma of the American College of Surgeons is sponsoring a program.

The Ohio Division of the American Cancer Society will present the program for the General Session on Wednesday morning.

On Friday morning, the faculty of Ohio State University College of Medicine will present a program.

### Section and Combined Sessions

Specialty Sections and Specialty organizations are arranging programs on Wednesday, Thursday and Friday afternoons as follows:

#### Wednesday Afternoon

Section on Internal Medicine and the Ohio Society of Internal Medicine.

Section on Occupational Medicine.

Section on Physical Medicine and the Ohio Society of Physical Medicine and Rehabilitation.

First session of Ohio Health Commissioners' Institute.

#### Thursday Afternoon

Section on Anesthesiology and Section on General Practice of Medicine.

Section on Ophthalmology and Ohio Ophthalmological Society.

Section on Ear, Nose and Throat.

Section on Radiology and the Ohio Chapter of the American College of Chest Physicians.

Conference on Laboratory Medicine.

Second session of the Ohio Health Commissioners' Institute.

#### Friday Afternoon

Section on Neurological Surgery and Ohio Neurosurgical Society.

Section on Obstetrics and Gynecology.

Section on Pathology and the Ohio Society of Pathologists.

Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics.

Section on Psychiatry and Neurology and the Ohio Psychiatric Association.

### The Exhibit and Other Features

The Scientific and Educational Exhibit is always an outstanding feature of the Annual Meeting. Here individual physicians or teams present their latest developments in research, in the teaching field, or in



## Leading Downtown Columbus Hotels and Prevailing Rates

### COLUMBUS PLAZA HOTEL (Headquarters)

50 N. Third Street

Singles .....	\$11.50 - 15.50
Twins .....	14.00 - 19.00

### DESHLER-COLE HOTEL

W. Broad & N. High Streets

Singles .....	\$ 7.50 - 14.50
Doubles .....	12.00 - 18.00
Twins .....	13.00 - 20.00

### NEIL HOUSE

41 So. High Street

Singles .....	\$ 8.50 - 15.00
Doubles .....	12.00 - 18.00
Twins .....	12.00 - 20.00

### HOTEL SOUTHERN

So. High & E. Main Streets

Singles .....	\$ 8.00 - 8.50
Doubles .....	11.00 - 11.50
Twins .....	11.50 - 13.00

### CHRISTOPHER INN

300 E. Broad Street

Singles .....	\$10.00 - 12.50
Doubles .....	13.00 - 15.00
Twins .....	17.00 - 18.00

### PICK-FORT HAYES HOTEL

31 W. Spring Street

Singles .....	\$ 7.50 - 13.00
Doubles .....	12.00 - 14.00
Twins .....	12.50 - 18.00

*All of the above rates include  
overnight parking of automobile.*

*Make Your*

## HOTEL RESERVATIONS

*... Now*

for the

## 1965 Annual Meeting

Ohio State Medical Association

COLUMBUS

MAY 9 - 14

### HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

\_\_\_\_\_  
(NAME OF HOTEL)

\_\_\_\_\_  
Columbus, Ohio  
(ADDRESS)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 9 - 14 (or for period indicated)

☐ Single Room

☐ Double Room

☐ Twin Room

Other accommodations \_\_\_\_\_

Price range \_\_\_\_\_

Arriving May \_\_\_\_ at \_\_\_\_ A.M. \_\_\_\_ P.M.

PLEASE VERIFY MY RESERVATION

Name \_\_\_\_\_

Address \_\_\_\_\_

some related field of educational value to physicians. As in recent years, a committee will examine the exhibits and select outstanding ones for special awards. A series of articles in *The Journal* featured the outstanding Scientific and Educational Exhibits selected as outstanding from the 1964 Annual Meeting.

Physicians and teams interested in presenting exhibits at the 1965 Annual Meeting in Columbus are reminded that the deadline for application is January 30.

The Technical Exhibit is another feature of educational value to physicians. This is the section in which exhibits are presented by supply houses and other organizations directly interested in filling the needs of physicians.

The President's Reception on Wednesday evening will be the social highlight of the Annual Meeting. Here members, their wives and guests may gather for refreshments and dancing. No dinner — no program — just an evening of entertainment with hors d'oeuvres furnished by the Association, and a cash bar for those who wish cocktails. Dress is optional.

The Woman's Auxiliary will hold its annual meeting at the same time as that of the Association. Auxiliary programs are scheduled in the Christopher Inn.

The House of Delegates, policy making body of the Association is meeting for its first session on Sunday, May 9, at the Columbus Plaza Hotel, beginning with dinner at 6:00 o'clock.

Reference Committees of the House of Delegates will meet on Monday, and, if necessary, on Tuesday. The Second Session of the House of Delegates will be on Tuesday, again beginning with a dinner at 6:00 P. M.

Headquarters will be the Columbus Plaza Hotel, where business sessions, the President's Reception and some other features will be held.

Most of scientific program will be in the Veterans Memorial Building, where Exhibits also will be displayed on the spacious exhibit floor.

### **Biennial Medicolegal Symposium Is Scheduled in Las Vegas**

The American Medical Association and the American Bar Association have joined forces to sponsor the 1965 National Medicolegal Symposium on March 11-13 at the Dunes Hotel in Las Vegas.

The meeting will provide the physician with an excellent educational opportunity on an important part of his professional life. Some 1,200 physicians and attorneys are expected to attend.

The biennial Medicolegal Symposium, sponsored solely by the AMA in the past, was considered to be the outstanding meeting of its kind. Participation by the American Bar Association promises an even more informative program.

## **Ohio Psychiatrists To Meet In Cincinnati, Jan. 20**

The Ohio Psychiatric Association will hold its winter meeting in Cincinnati on Wednesday, January 20, at the Terrace Hilton Hotel.

Luncheon speaker will be Dr. Herbert Modlin, of the Menninger Foundation, whose topic will be "Training for Community Psychiatry."

Afternoon program will include the following speakers and topics:

Edward Kezur, M. D., Hamilton, "College Psychiatry, a Challenge." Discussant — Horatio Wood, IV, M. D., Cincinnati.

J. M. Wittenbrook, M. D., Cleveland, "Resistance to Therapy as Seen in Private Practice." Discussant — Leslie E. Whitmire, M. D., Toledo.

J. A. Whieldon, M. D., Columbus, "The Hyperkinetic Brain Damaged Child." Discussant — William Boniface, M. D., Cincinnati.

Pedro A. Corrons, M. D., Columbus, "Directed Artistic Creativity as an Accelerating Technique in Dynamic Psychotherapy." Discussant — William E. Powles, M. D., Cincinnati.

The foregoing scientific session will be followed by a business meeting which will include task force reports of the following subcommittee chairmen:

Harold Hiatt, M. D., Cincinnati, chairman, Subcommittee on Treatment.

Philip Rond, M. D., Columbus, chairman, Subcommittee on Rehabilitation.

Everett Shimp, Ph. D., Columbus, chairman, Subcommittee on Manpower.

In the evening, the group will hold a combined meeting with the Cincinnati Society of Neurology and Psychiatry at the Emerson A. North Hospital, 5642 Hamilton Avenue, Cincinnati, for cocktails, dinner and a program.

Evening speaker will be Elizabeth Crosby, Ph. D., professor emeritus of anatomy, University of Michigan and University of Alabama, and consultant in neurosurgery, University of Michigan, whose topic will be "Experimental Studies on Changes in Tonus with Some Clinical Applications."

Reservations for the luncheon (\$3.25 per person) may be made by contacting Milton Kramer, M. D., Program Chairman, Veterans Administration Hospital, 3200 Vine Street, Cincinnati, Ohio 45220.

Any university graduate or graduate of a school of nursing who is interested in entering the field of health education may apply for the Lester Yaylor Memorial Scholarship and 12 weeks of study at the Cleveland Health Museum, 8911 Euclid Ave., Cleveland. Deadline is March 30 for the 1965 award application.



# APPLICATION FOR SPACE, SCIENTIFIC AND EDUCATIONAL EXHIBIT, OHIO STATE MEDICAL ASSOCIATION, 1965 ANNUAL MEETING, VETERANS MEMORIAL BUILDING, COLUMBUS, OHIO, MAY 9 - 14

1. Title of Exhibit: \_\_\_\_\_

2. Name(s) of Exhibitor(s): \_\_\_\_\_

Institution (if desired): \_\_\_\_\_

City \_\_\_\_\_

3. Do you have a built-in exhibit? \_\_\_\_\_

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

Charts and posters \_\_\_\_\_ Photographs \_\_\_\_\_ Drawings \_\_\_\_\_ X-rays \_\_\_\_\_

Specimens \_\_\_\_\_ Moulages \_\_\_\_\_ Other material \_\_\_\_\_

(Describe)

6. Booth Requirements:

Amount of wall space needed? \_\_\_\_\_

Back wall \_\_\_\_\_ Side walls \_\_\_\_\_

Square feet needed? \_\_\_\_\_

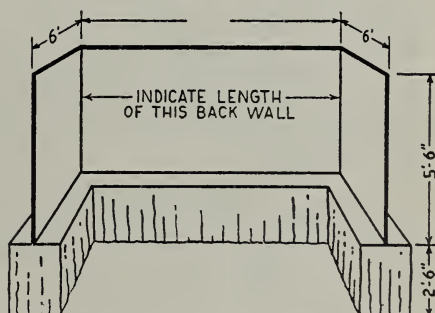
Shelf desired? (yes or no) \_\_\_\_\_

7. Transparency Cases:

Needed? (yes or no) \_\_\_\_\_

If answer "yes," give following information:

Number of transparencies to be shown and size of each \_\_\_\_\_



*Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.*

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Educational Exhibit, Ohio State Medical Association" which will be supplied to all applicants.

Date \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Mailing Address, Street \_\_\_\_\_

City, Zone, State \_\_\_\_\_

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND EDUCATIONAL EXHIBIT,  
OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS, OHIO 43215  
DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1965

# Proceedings of The Council...

## Matters Considered at Fall Meeting in Columbus. September 18-20, with Reports of Actions Taken

THE regular Fall meeting of The Council was held at Stouffer's University Inn, Columbus, Friday, Saturday and Sunday, September 18, 19, 20, 1964. All members of The Council were in attendance. Also in attendance were the following: Dr. Charles L. Hudson, Cleveland, a member of the AMA Board of Trustees and Past-President of the OSMA; the following Ohio delegates and alternates to the AMA: Drs. Edwin H. Artman, Chillicothe; John H. Budd, Cleveland; Richard L. Meiling, Columbus; Paul F. Orr, Perrysburg; Charles A. Sebastian, Cincinnati; George W. Petznick, Cleveland; Carl A. Lincke, Carrollton; Edmond K. Yantes, Wilmington; Frederick P. Osgood, Toledo; J. Robert Hudson, Cincinnati; Robert S. Martin, Zanesville; Kenneth D. Arn, Dayton; Harry K. Hines, Cincinnati; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; and the following members of the OSMA staff: Messrs. Saville, Page, Edgar, Moore, Gillen and Traphagan.

### Minutes Approved

The minutes of the meeting of The Council held on July 25-26, 1964, were approved by official action.

### Reports by Councilors

Reports were given by individual Councilors on activities in their respective districts.

### Membership Statistics

The Executive Secretary presented a report on membership as follows: OSMA membership 9,805, as of September 18, 1964, compared to a total membership at the end of 1963 of 9,743. The report stated that of the 9,805 OSMA members, 8,835 were affiliated with the AMA.

### Policy on Waiver of Dues for 1965 Adopted

By official action, The Council adopted the following policy with respect to waiver of annual dues for the calendar year 1965:

A. That dues for new members in practice, affiliating with the OSMA during the last six months of the calendar year 1965, namely, July 1 to December 31, inclusive, shall be \$17.50, one-half the regular per capita dues of \$35.00. The pro-rating of dues shall not apply to former members reaffiliating.

B. That the following procedures shall apply during 1965 with respect to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

1. State Association dues for 1965 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.

2. State Association dues for 1965 shall be waived for physicians who were members of the Association in 1964 and who enter such services during the calendar year 1965 before the payment of 1965 dues.

3. A refund of membership dues will not be made if a member enters such services in 1965 after his dues are received at the Columbus office of the Association.

4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

C. Annual Ohio State Medical Association dues for 1965 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be \$7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges.

### Report of Committee on Scientific Work

Dr. Tschantz then called for the report of the Committee on Scientific Work which had met on Saturday, August 29, with the section officers and representatives of the various specialty groups and on August 30 for the purpose of making preliminary arrangements for the 1965 Annual Meeting in Columbus, May 9-14. Mr. Page, secretary of that committee, reported for that committee. The Council, by official action, approved the committee's report.

### Attendance Committee To Be Appointed

The President was authorized to appoint a committee on annual meeting attendance promotion, and



the Councilors were asked to submit suggestions for the personnel of this committee.

#### Thursday Evening General Session

The Council authorized the President to explore the possibilities of scheduling a guest speaker of national importance for the afternoon or evening of Thursday, May 13.

#### Changes in Names of Scientific Sections

By official action, The Council approved changes in the names of the following sections: Section on Nervous and Mental Diseases to the Section on Psychiatry and Neurology; and the Section on Otorhinolaryngology to the Section on Ear, Nose and Throat.

#### General Sessions Scheduled

The Council approved the scheduling of the general session program by the Ohio State Heart Association on Thursday morning, May 13, and the general session to be sponsored by the Ohio State University College of Medicine on Friday morning, May 14.

#### AMA Educational Campaign

Mr. Edgar described the AMA educational campaign, "Health Opportunity Program for the Elderly." The Council approved the expenditure by the Ohio State Medical Association of funds to carry out the educational campaign advertising in Ohio non-metropolitan daily newspapers. The Council also authorized the use of the name and address of the Ohio State Medical Association on advertisements in those counties where a county medical society failed to approve the use of its signature.

It was decided that the County Medical Society, when granting permission to use its signature on the advertising, should have the opportunity to designate whether only the society name should be carried or also the telephone number of the society. It was further decided that each county medical society would be asked to return to the headquarters office written authority to have the advertisements appear in the newspapers in its county.

#### Bar Association President Introduced

At this time Mr. Roger H. Smith, Toledo, President of the Ohio State Bar Association, was introduced as a guest. Mr. Smith spoke briefly to The Council.

#### Report of AMA Delegates and Alternates

Dr. John H. Budd, Cleveland, chairman of the Ohio delegation, reported on the meeting of the AMA Delegates and Alternates held on Friday evening, September 18. Highlights of Dr. Budd's report included the following:

1. That the OSMA encourage the appointment of Dr. Richard L. Meiling, Columbus, to membership on the AMA's new Commission on Research, the purpose of this commission being to study Federal grants for medical research.
2. That the Ohio delegation submit the name of

#### How Do You Rate The Journal as A Professional Publication?

Among the top professional publications that you read, where do you place *The Journal*? See the last page of this issue and the questionnaire post card for your brief comments. A good return on this post card will help the staff produce a better Journal.

Dr. Charles L. Hudson, Cleveland, for nomination for the office of President-Elect of the American Medical Association at the 1965 Annual Convention in New York City and that appropriate steps be taken to enlist the support of other state delegations for Dr. Hudson's candidacy and election.

3. That the Ohio delegation submit at the 1964 Clinical Convention in Miami Beach, November 29 - December 2, a resolution asking that a study be made toward changing the present AMA procedure for seating delegates and alternate-delegates in order that the state delegations and other groups may be assured of seating of their full complement of delegates at each meeting of the AMA House of Delegates.

It also was reported that Dr. Budd was re-elected chairman of the Ohio delegation and Dr. George W. Petznick, Cleveland, vice-chairman.

The delegation also requested that The Council approve an open house at the clinical convention in Miami Beach and at the 1965 Annual Convention in New York City.

Dr. Budd's recommendations and his report as a whole were approved by official action of The Council.

#### Teaching of Medical Subjects in School of Optometry

A proposed letter directed to the Ohio State University Board of Trustees regarding the teaching of medical subjects in the School of Optometry in the College of Medicine was approved, as amended, on motion duly made, seconded and carried. The text of the proposed letter follows:

"We understand that the Ohio State University's Bulletin of Courses of Instruction for the year of 1964-1965 includes courses for students of optometry in 'Pathology 650' and 'Ophthalmic Pathology 651.' We further understand that these courses will be taught by one or more of the Professors, Associate Professors or Assistant Professors listed under the subject 'Pathology' on page A-178 of this Bulletin, some of which faculty members are duly licensed Doctors of Medicine.

"In the opinion of The Council of the Ohio State Medical Association, the teaching by a Doctor of Medicine of medical subjects to students in optometry raises a very serious question of unethical conduct — a violation of the Principles of Medical Ethics of the American Medical Association.

tion — on the part of such Doctor of Medicine. This is a question that is of vital concern to your faculty members who are Doctors of Medicine, to the medical profession and our Association, and to the public generally.

"Accordingly, The Council of the Ohio State Medical Association respectfully requests that no faculty member holding the degree of Doctor of Medicine be required or requested by the University to teach any medical subject to any student who is enrolled in the University's School of Optometry or who is preparing to practice or teach optometry.

"We shall greatly appreciate your favorable consideration of this request and your advising us promptly when you have reached a decision on this important matter."

### Committee Reports Approved

By official action, The Council approved the following committee reports:

**Occupational Health**, presented by Mr. Charles W. Edgar and based on minutes of a meeting of that committee held on August 5.

The Council voted to support, but not initiate, legislation to amend Section 741.18 of the Ohio Revised Code. The effect of this section is to establish by law a causal relationship between the occupational activities of a fireman and the occurrence, at any time within his term of employment as a fireman, of any type of disease of the heart, unless his cardiac disability shall have been found to be in existence and so recorded at the time of his employment. It was felt that this amounts in practice to the making of a medical diagnosis through legislation and that it should be removed from the Code in the interest of municipal fire fighters and in the interest of the general public.

**Joint Advisory Committee on Athletic Injuries**, presented by Mr. Herbert E. Gillen and based on minutes of a meeting of that committee held on September 2.

Mr. Gillen also reported on the Third Postgraduate Institute for Physicians on Medical Aspects of Teenage Athletics, held on August 26-27, on the O.S.U. campus.

**Committee on Laboratory Medicine**, presented by Mr. W. Michael Traphagan and based on minutes of a meeting of that committee held on September 12.

**Committee on Medicine and Religion**, presented by Dr. Petznick and Mr. Traphagan and based on minutes of a meeting of that committee held on September 13.

**Committee on Maternal Health**, presented by Dr. Anthony Ruppertsberg, Jr., and based on the Maternal Mortality Report for Ohio in 1961. In approving this report, The Council commended the committee on its fine work and requested that the report be published in *The Ohio State Medical Journal*.

### Report of Ohio Director of Health

Dr. Emmett W. Arnold, Ohio Director of Health, then addressed The Council. He thanked the Association and its staff for their cooperation and discussed with The Council a number of public health problems.

### 1964 AMA-ERF Campaign

Mr. Traphagan reported on the 1964 AMA-ERF campaign in Ohio, emphasizing student loans as well as gifts for medical schools. The report was approved by official action.

### Revisions in Pharmacy Regulations

The proposed revisions in the regulations of the State Board of Pharmacy were reviewed by Mr. Page for the information of The Council.

### Vocational Rehabilitation Project

Mr. Saville reported on the proposed vocational rehabilitation project in Licking and Muskingum Counties.

### Ohio 65 Health Insurance Program

A resolution concerning the Ohio 65 Health Insurance program was approved by official action. The text of the resolution is as follows:

"WHEREAS, The health, happiness, protection and security of Ohio's elderly residents is of vital concern to all civic-minded and public spirited organizations; and

"WHEREAS, Improved techniques and advancements in medical science and research have succeeded in prolonging the life span of the individual, and

"WHEREAS, Legislation recently enacted by the Ohio General Assembly has enabled the private insurance companies comprising the Ohio 65 Health Insurance Association to band together to make available on a voluntary basis health and medical care insurance coverage for Ohio residents 65 years of age and over;

"NOW THEREFORE, BE IT RESOLVED, That these private companies in the Ohio 65 Health Insurance Association be commended for this voluntary program conducted under America's free enterprise system."

### Reports on AMA Institute and MSEA Institute

Mr. Saville and Mr. Page reviewed the American Medical Association Public Relations Institute and the Medical Society Executives Conference held in Chicago in August. Both meetings were reported to be excellent.

### Journal Advertising Contract Cancelled

On motion duly made, seconded and carried, The Council voted to cancel the contract of *The Ohio State Medical Journal* with Mr. Oscar A. Bergman,



Cleveland, advertising representative, effective October 31, 1964.

### Today's Health Subscriptions

In answer to a notice that the Woman's Auxiliary to the AMA could no longer provide complimentary subscriptions of *Today's Health* to the colleges of Ohio, The Council voted to appropriate funds sufficient to provide a subscription for each Ohio college.

### 1965 County Society Officers Conference

It was announced that the 1965 OSMA County Society Officers Conference will be held at the Columbus Plaza on February 28. Suggestions for programming included "regional hospital planning," "practical politics," "legal do's and don'ts" and "forces outside medicine affecting medicine."

### Ohio Society of Medical Assistants

The Council appropriated \$500.00 for the Ohio Society of Medical Assistants for the purpose of assisting the society to complete the financing of its organizational structure.

### Subcommittee on School Bus Driver Examinations

By official action, The Council approved the establishment of a Subcommittee on School Bus Driver Examinations to serve in an advisory capacity to the Ohio Department of Education in regard to the physical examination of school bus drivers. The personnel of this subcommittee will be taken from the OSMA Committee on Traffic Safety and the OSMA Committee on School Health.

### Hospital Utilization Committees

Mr. Stichter presented an informal discussion on the use of hospital records by utilization committees.

### Ad Hoc Committee Appointed

President Tschantz announced the appointment of an ad hoc committee to study the implementation of Resolution No. 3, enacted at the 1964 session of the House of Delegates, regarding possible methods of announcing a nominee or nominees for the office of president-elect prior to the annual meeting. Also assigned to the committee was the carrying out of the provisions of an addendum to the report of the Committee on Nominations for the 1964 Annual Meeting which recommended a study of the provisions of Chapter 5 of the Bylaws in order to suggest changes to define clearly the scope, function and authority of the Committee on Nominations and prescribe for it an orderly procedure. The committee is to report at the 1965 meeting of the House of Delegates. Following is the personnel of the committee: Drs. P. John Robeck, Cleveland, chairman; Maurice F. Lieber, Canton; James G. Roberts, Akron; Frederick P. Osgood, Toledo; Carl A. Lincke, Carrollton; Harry K. Hines, Cincinnati; Richard L. Fulton, Columbus.

### Boards for the Adjudication of Fees

With regard to Resolution 4 at the 1964 session of the OSMA House of Delegates, which pertained to boards for the adjudication of fees, it was agreed that these matters should be handled by the regular grievance committee structure of the county medical societies and the Ohio State Medical Association, and that the existing policy of the Association, as expressed by The Council on December 16-17, 1961, be reaffirmed.

### AMA Delegates and Alternates

It was the sense of The Council that AMA Delegates and Alternates attend Council meetings if they choose, but that it is no longer mandatory for them to be present at all meetings.

It was suggested that the chairman of the Ohio delegation to the AMA attend each Council meeting or designate another delegate to attend in his place.

If the nature of the agenda necessitates the attendance of delegates and alternates, they are to receive notice in advance that such meeting is an essential one for them to attend.

### Insurance Committee To Be Appointed

The Council approved the establishment of a Committee on Insurance and members of The Council were requested to submit suggested names for members to be considered for appointment to the committee by the President.

### Mental Health Legislation

By official action, The Council suggested that the Cleveland Academy of Medicine reappoint its Subcommittee on Mental Health Legislation as an "ad hoc" committee to complete the study which was begun by this subcommittee.

### Membership of Licensed Non-Citizen Physicians

The Council discussed informally the question of eligibility for membership of physicians licensed in Ohio who are practicing in this state but who are not citizens and apparently do not plan to establish citizenship.

### Fifty-Year Certificates

Fifty-year certificates and gold emblems were distributed to members of The Council for presentation to eligible 50-year members in the county medical societies in their districts.

### Date for December Meeting

Dr. Tschantz announced that the December meeting of The Council would be held on Saturday and Sunday, December 12-13.

There being no further business, The Council adjourned.

Attest: HART F. PAGE,  
*Assistant Executive Secretary.*

## Do You Know? . . .

Dr. Charles H. Rammelkamp, Jr., director of medicine at Metropolitan General Hospital in Cleveland, has been named to the National Advisory Heart Council, the official advisory board to the National Heart Institute.

\* \* \*

Dr. Homer A. Anderson, president of the Academy of Medicine of Columbus and Franklin County, was elected to the Board of Trustees of the Central Hospital Service, the Blue Cross organization in central Ohio.

\* \* \*

Dr. Margaret J. Schneider, Cincinnati, was named president-elect of the American Medical Women's Association at the annual meeting in New York City.

\* \* \*

Dr. Morris Fishbein, well-known speaker and editor, was principal speaker at a dinner meeting to promote the building campaign of the Akron General Hospital. A proposed nine-story wing will increase the hospital's capacity from 452 to 648 beds.

\* \* \*

John R. Wilson, D. D. S., succeeded Wendell D. Postle, D. D. S., as dean of the Ohio State University College of Dentistry, effective January 1. Associate dean since 1958, Dr. Wilson has been a faculty member at the college since 1946.

\* \* \*

Dr. Chester C. Winter, professor of surgery and director of the Division of Urology in the Ohio State University College of Medicine, has been invited to lecture before the Royal Society of Medicine January 28 in London. He will be the speaker for the annual H. P. Winsbury-White Memorial Lecture, which honors the late surgeon-editor of the textbook: *Genito-Urinary Surgery*, on the topic "Radioisotope Renography: The First Decade."

\* \* \*

Dr. Floyd I. Hudson, Executive Secretary of the Delaware State Board of Health, was elected president of the Association of State and Territorial Health Officers at the recent annual conference.

\* \* \*

The Southwestern Ohio Society of Family Physicians met on November 22 in cooperation with the University of Cincinnati College of Medicine. Subject for the Seminar was "The Problem Child at School and Home."

\* \* \*

The Fort Steuben Academy of Medicine had as guest speaker on December 8, Dr. Loton H. Rasmussen, attending physician, Medical Service, Memorial Hospital, New York City, whose subject was "The Immunity of the Lymphomas." The dinner meeting was held in the Fort Steuben Hotel, Steubenville.

## Cleveland Medical Center Project Promoted by Prentiss Grant

The Elisabeth Severence Prentiss Foundation has approved a grant of \$1,000,000 to the University Medical Center Development Program.

The Medical Center Program is an eight-year \$54,800,000 effort by University Hospitals of Cleveland and the Schools of Medicine, Dentistry and Nursing of Western Reserve University to provide new and remodeled patient care, education and research facilities.

The Prentiss Foundation gift will be used to memorialize the new 26-room surgical operating suite at University Hospitals in the name of Dr. Dudley Peter Allen, personality at the Medical Center around the turn of the century. The operating suite will be located in the \$10,000,000 Robert H. Bishop, Jr., Building which was started by University Hospitals this summer.

The gift by the Prentiss Foundation raised to \$8,065,000 the amount awarded the Medical Center by local and national foundations so far. Other gifts and grants include:

Leonard C. Hanna, Jr., Fund, \$5,000,000; The Commonwealth Fund, \$500,000; Louis D. Beaumont Foundation, \$500,000; Claude Foster Building Fund, \$400,000; Cleveland Foundation, \$300,000; Avalon Foundation, \$200,000; Kulas Foundation, \$65,000; Eugene S. and Blanche R. Halle Fund, \$50,000; The Kresge Foundation, \$25,000, and Knight Youth Foundation, \$25,000.

### Akron Medical School Backers Incorporate Their Group

Secretary of State Ted Brown issued nonprofit articles of incorporation (Nov. 26) to The Akron Area Medical College and Education Foundation, formed to promote a medical college or medical center in the Akron area.

The foundation is an outgrowth of Mayor Erickson's committee to study the establishment of a medical school in Akron.

It's patterned after a successful Toledo effort, and as a non-profit corporation it can become a repository for funds.

First aim of the Foundation is to bring up to date the study of its predecessor committee, which had recommended building a medical school for Akron University and later adding a hospital.

Once the study is in final form, the Foundation will begin seeking funds from state, federal and private agencies. — *Akron Beacon Journal*.

Dr. Richard J. Watkins, Wooster, was guest speaker at a meeting of the Apple Creek Parent-Teacher Association, where he showed slides and related experiences as member of a Care-Medico team in Algeria.



## Dr. Merchant Is Reappointed To State Medical Board

Dr. Frederick T. Merchant, Marion, has been reappointed for an additional seven-year term on the State Medical Board of Ohio, it was announced recently from the Governor's office. The term of office runs to June of 1971.

In addition to his service on the official licensing board, Dr. Merchant is active in medical organization work and at present is a member of The Council of the Ohio State Medical Association, serving as Councilor of the Third District.

Other members of the Board are Dr. John N. McCann, Youngstown, president; Dr. W. M. Hoyt, Grove City, vice-president; Dr. John D. Brumbaugh, Akron; Dr. Donald F. Bowers, Columbus; Dr. Domenic A. Macedonia, Steubenville; Dr. J. O. Watson, Columbus, the osteopathic member; and Dr. Mervin F. Steves, Cincinnati. Dr. H. M. Platter, is secretary of the Board.

## Butler County Medical Society Announces Annual Seminar

The Butler County Medical Society announces its Third Annual Post-Graduate Medical Seminar to be held on Wednesday, January 27, in Hamilton at the Elks Country Club.

"Trauma in Children" is the subject for discussion for a program beginning at 12:30 p. m. and ending with a panel question and answer period at 4:30 p. m. All members of the Ohio State Medical Association are welcome to attend.

The following will appear on the program:

Robert J. Izant, Jr., M. D., director, Division Pediatric Surgery, Western Reserve University — "Overall Problems in the Injured Child";

John DePrez, M. D., assistant professor plastic surgery, Western Reserve University — "Injuries of the Face in Children";

Earl S. Sherard, M. D., assistant professor pediatrics, Ohio State University — "Psychic Considerations of the Child With Multiple Trauma";

Kingsbury G. Heiple, M. D., assistant professor orthopaedic surgery, Western Reserve University — "Orthopaedic Considerations in the Child With Multiple Injuries";

John H. Davis, M. D., Associate Professor Surgery, Western Reserve University — "The Burned Child";

Robert J. White, M. D., assistant professor of neurosurgery, Western Reserve University — "Head Injuries in Children."

As in the past, credit will be allowed for Category I, American Academy of General Practice.

Cocktails and dinner will be served in the evening, and dancing will follow. The cost for the entire program will be \$20.00 per couple.

## New Assignments Are Announced On OSMA Executive Staff

Following a meeting of The Council of the Ohio State Medical Association on December 12-13, Dr. Robert E. Tschantz, OSMA President, announced new assignments for three members of the Executive Staff.

At his own request, Executive Secretary George H. Saville was placed on a consultant status. Mr. Saville's request was made on the advice of his physician after recent hospitalization. He and Mrs.

Saville are planning a winter vacation in Florida.

A member of the OSMA Executive Staff since 1935, Mr. Saville was Assistant Executive Secretary and Director of Public Relations for many years before being named to the top executive post. He will become eligible for retirement under the Association's retirement program at the end of this year.



G. H. (Scottie) Saville

Nationally recognized in the field of organization and public relations, Mr. Saville is former chairman of the Advisory Committee to the Division of Communications of the American Medical Association and former member of the Board of Directors of the Public Relations Society of America. He also is a member of the Medical Society Executives Association.

His interests in organization work began with participation in alumni affairs of his Alma Mater, Ohio Wesleyan University, Delaware. He has been both national president of the Alumni Association and national president of the Alumni Fund Council of Ohio Wesleyan. In local affairs he was president of the Columbus Public Relations Society and of the Ohio Society of Trade Executives.

Hart F. Page, a member of the Executive Staff for 19 years and recently Assistant Executive Secretary as well as Director of Public Relations, has been named Acting Executive Secretary.

Charles W. Edgar, an Executive Staff member since 1956, and recently Executive Assistant, has been named Acting Director of Public Relations and Acting Assistant Executive Secretary.

Other actions of The Council at its December 12-13 meeting will be reported in the official proceedings to be published in the February issue of *The Journal*.

Dr. Bruce D. Graham, Columbus, was appointed to the Committee on Hospital Care of the American Academy of Pediatrics.

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*

— Justice Robert H. Jackson in AAA Supreme Court Case, 1942

## **"SCOTTIE" STEPS DOWN AFTER LONG SERVICE WITH ASSOCIATION**

The pre-holiday season was touched with nostalgia when George H. Saville announced at the December meeting of The Council that he wished to step down from his duties as Executive Secretary of the Association. At The Council meeting, and later before a staff meeting in the OSMA headquarters office, Mr. Saville explained that his request was presented for health reasons and that this action was based on the advice of his physician, following recent hospitalization.

Mr. Saville, who is known among his many friends as "Scottie," has virtually devoted a lifetime to the service of the Association. Since 1935 when the Association's membership was not much more than half of what it is today, Mr. Saville has worked tirelessly in helping to develop positive programs in behalf of organized medicine and the public's health.

He has helped present organized medicine's point of view through liaison with numerous organizations and individuals, including the Ohio General Assembly and its members. His attendance at many national meetings, including conventions of the American Medical Association, has helped to present Ohio's viewpoints on the national level and has kept the home front informed on what is developing in other areas.

In Ohio, Scottie Saville has devoted his time and his energies through the services of the Association's headquarters office. Members of the Association, as well as its officers and Councilors, have found in him a friend, a counselor and a willing worker.

Perhaps, with all of his activities, his closest ties were with other members of the OSMA staff — a staff which has grown from four when he first came with the Association to 17 full-time employees at present. His willingness to listen when a problem arose and his counsel when the going got tough gave him special esteem in the eyes of his fellow staff members and OSMA members.

As Scottie Saville goes to a consultant status with the Association, he has the best wishes of his many friends that he may enjoy years of health and happiness.

## **HOW DO MEMBERS READ THE JOURNAL? AN IMPORTANT QUESTION**

Pharmaceutical advertising plays a double role in a professional publication such as *The Journal*. In the first place, it is educational. In the second place, it helps to pay the cost of producing *The Journal* and thus relieves the Association's members of a heavy financial burden.

But *The Journal*, with virtually every other State Medical Journal in the country, is facing a dilemma as far as pharmaceutical advertising is concerned. Ethical pharmaceutical manufacturers are going elsewhere to promote their products to the doctors.

*The Journal* staff makes only one promise to its advertisers: That it will place their messages in the hands of more than 9500 doctors of medicine each month.

In this issue we are going a step farther. With the approval of The Council, a readership survey in the form of a brief postcard questionnaire is placed on the last page of this issue. Each member of the Association is earnestly requested to return this card with his comments.

Such a readership survey, brief as it may seem, is invaluable to the staff and to the officers of the Association. It is valuable from another standpoint also. A well-read Journal invites the top echelon of advertisers and advertisers pay the lion's share of production costs.

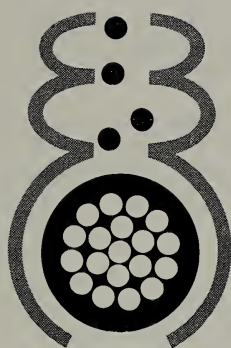
Comments by *The Journal's* readers are always welcome by the Editor, by other members of the staff and by the officers of the Association. At this time, however, we need a spontaneous response from readers. Please take a few moments to remove the postcard from the last page of this issue and return it with your brief comments.

## **CONTINUED OPPOSITION TO MEDICARE, A MATTER OF "HONOR AND DUTY"**

Physicians who may feel taken aback by the turn of recent events, can take renewed courage from an editorial that appeared recently in the *Akron Beacon Journal*.

Under the heading "No Compromise," the editorial comments on the speech of Dr. Donovan F.





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Each tablet and each 5 cc. of liquid contains:  
diphenoxylate hydrochloride . . . . . 2.5 mg.  
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- lowers motility promptly
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Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

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The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

## cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

## SEARLE

*Research in the Service of Medicine*

Ward, president of the American Medical Association, at the AMA convention in Miami Beach.

Here are the concluding paragraphs of the editorial:

"If (Rep. Wilbur) Mills is correct, adoption of the administration (medicare) bill would be followed by widespread disillusionment.

"Then what?

"A great demand among elderly persons, and their children, for liberalization of the program to make it cover all health needs — prescription drugs, full payment of hospital and nursing home bills, full payment of physicians' and surgeons' and dentists' bills.

"Medicare as it stands is a far cry from socialized medicine. But socialized medicine is what it inevitably would become.

"Whether the majority of Americans agree with them or not, the majority of the nation's doctors sincerely believe that socialized medicine would adversely affect the quality of health care. This is why the AMA sees continued opposition to medicare as a matter of 'honor and duty.'"

#### THE AMA — A STUDY IN POSITIVE ACTIVITIES

Among New Year's Resolutions, perhaps a good one would be to take a second look at the POSITIVE side of the American Medical Association's programs and activities. We hear too much what the AMA is AGAINST, and not enough about what it is FOR.

The annual reports of the AMA, submitted to the House of Delegates and published in the October 26 issue of *The Journal of the AMA*, are a cue to

activities. One of these activities was the honoring of two teenage scientists for their outstanding exhibits in the National Science Fair. Another activity is promotion of the World Medical Association. Between these two extremes are reports on hundreds of programs in which the AMA is reaching out to promote good practice of medicine and to protect the public health.

Legislative activities is one field in which the AMA is criticized wrongfully. During the year covered by the report, the AMA Legislative Department had to scan 6,965 bills to screen out 400 that were of interest from a medical or public health standpoint. It also examined 36,192 pages of the *Congressional Record*, 16,270 pages of the *Federal Register*, 233 Congressional Reports, and 48 printed reports of hearings. The AMA presented prepared comments on 23 bills, most of the comments being of a positive nature.

Obviously the AMA is against quackery, against governmental control of the practice of medicine, and against anything else that would downgrade efficient medical practice. But, on the other hand, it is for high standards in medical education, it is for good public health measures, it is for liaison with other professional organizations; in short, it is for anything that will improve the practice of medicine and protect the public's health.

Ohio is well represented with more than 8,900 physicians who are members of the AMA. Looking at the record, it should be supported by every physician who values the free practice of medicine in a free society.

## Deadline for Submission of Resolutions to Columbus Office of the Association Is March 10

**D**ELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1965 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal*, must be introduced at the first session of the House of Delegates, Sunday evening, May 9, at the Columbus Plaza Hotel.
2. When the resolution is introduced, copies in triplicate should be presented.
3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 10. This requirement may be waived by a two-thirds majority of the House of Delegates.
4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.



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Some cough mixtures claim they stop coughs. Others say they soothe, allay or relieve coughs.

One prescription—Dilaudid Cough Syrup—approaches the ideal: *fewer but better coughs*. It gives a degree of antitussive action needed for the persistent, racking, unproductive cough that ordinary codeine or codeine-like substances cannot match. Also, it liquifies troublesome mucus to make the cough more productive.

You have to prescribe it.

Your patients will be glad you did. They'll be coughing better.

The usual therapeutic dose is one teaspoonful (5 ml.) repeated every three to four hours. The dose for children should be adjusted according to age and body weight. Each 5 ml. of Dilaudid Cough Syrup contains 1 mg. hydromorphone and 100 mg. glyceryl guaiacolate in a pleasant-tasting, peach-flavored vehicle containing 5% alcohol. Subject to Federal Narcotic Regulations.

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# Ad Astra

Richard Vincent Clifford, M.D., Youngstown; Georgetown University School of Medicine, 1931; aged 58; died November 18; member of the Ohio State Medical Association and the American Medical Association. A practicing physician and surgeon in Youngstown since 1932, Dr. Clifford was a veteran of World War II, having served in the U. S. Navy Medical Corps. He is survived by his widow and three children.

Thomas Matthew Crinnion, M.D., Toledo; Toledo Medical College, 1903; aged 86; died November 10; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A lifelong resident of Toledo, Dr. Crinnion practiced medicine and surgery there for nearly 60 years before his retirement two years ago. He was a trustee of the Former DeSales College in Toledo and a director of the University of Toledo. A son survives.

Frank Denton Crowl, M.D., Dayton; University of Pennsylvania School of Medicine, 1907; aged 82; died November 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Crowl practiced medicine for about 45 years in the Dayton area before his retirement in 1953. Survivors include his widow and three sons.

Alfred Harry Crum, M.D., Cincinnati; Eclectic Medical College of Cincinnati, 1921; aged 66; died November 27; member of the Ohio State Medical Association. A practicing physician for many years in Cincinnati, Dr. Crum specialized in urology. He was a member of several Masonic bodies, and was on the board of managers of Bethesda and Deaconess Hospitals. Survivors include his widow and two daughters.

Ralph Stuart Dial, M.D., Cleveland; Yale University School of Medicine, 1925; aged 63; died November 22; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology. Dr. Dial was a member of a family of physicians. His father was the late Dr. Emery Dial. Two surviving brothers are Dr. Robert Dial and Dr. Donald Dial. A practicing physician in Cleveland, Dr. Ralph Dial specialized in obstetrics and gynecology. Besides his brothers, he is survived by his widow, a son, a step-son and a step-daughter.

Irene Selymes Endrey, M.D., Cleveland; medical degree from the University of Budapest, 1912; aged 75; died November 22; former member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Former residents of Budapest, Hungary, Dr. Endrey and her husband, the late Dr. Laczlo Endrey moved to Cleveland in 1924, where both practiced for many years. Survivors include a daughter and two sisters, Dr. Charlotte Selymas and Dr. Piroska Selymas.

John Gardiner, III, M.D., Norwalk; Johns Hopkins University School of Medicine, 1935; aged 56; died November 20; member of the Ohio State Medical Association and the American Medical Association. A native of Norwalk, Dr. Gardiner returned there to practice after approximately 15 years of service in the Army Medical Corps. He served in the Pacific Theater during World War II and attained the rank of lieutenant colonel. A member of the Episcopal Church, he is survived by his widow, a son and his father.

Thorp Alexis Klumph, M.D., Woodland Hills, Calif.; Western Reserve University School of Medicine, 1945; aged 42; died November 16; former member of the Ohio State Medical Association. Dr. Thorp practiced for about 10 years in Parma before moving to California in 1960. Surviving are his widow, three sons and a daughter.

Thomas Longworth, M.D., Felicity; Medical College of Ohio, Cincinnati, 1905; aged 84; died November 14; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Longworth's entire professional career of more than a half century was served in the Clermont County area. In addition to his professional associations, he was a member of several Masonic bodies. A daughter survives.

Hugh A. McFadyen, M.D., Columbus; University of Western Ontario Faculty of Medicine, 1912; aged 82; died on or about November 5. A practicing physician of many years standing in Detroit, Mich., Dr. McFadyen was living in Columbus in retirement. Two brothers survive.

Robert Leeper Puncheon, M.D., Brilliant; Temple University School of Medicine, 1945; aged 45; died November 22; member of the Ohio State Medical



Association and the American Medical Association. A practicing physician for 18 years in the Jefferson County community, Dr. Puncheon was a veteran of World War II, having served in the Navy. He was a member of the American Legion, several Masonic bodies, the Lions Club and the Presbyterian Church. Survivors include his widow, three sons, his mother and a sister.

**Karl Dresbach Reichelderfer, M. D.,** Columbus; Ohio State University College of Medicine, 1921; aged 70; died November 15; member of the Ohio State Medical Association and the American Medical Association. Dr. Reichelderfer practiced for about 21 years in the Bexley area of Greater Columbus, and previously practiced at Wheelersburg in Scioto County. His widow survives.

**Thomas Scott Simms, M. D.,** Columbus; Starling Medical College, Columbus, 1900; aged 96; died November 22. A former practitioner in Savannah in Ashland County and Ashland County corner, Dr. Simms had made his residence in Columbus for many years. He is survived by his widow, a son, a daughter and a sister.

**Roman W. Stetkevich, M. D.,** Sheffield Village; medical degree from Polish university in Lemberg; aged 45; died November 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of the Ukraine, Dr. Stetkevich came to this country shortly after World War II. He came to Ohio from Detroit in 1953 and practiced for more than 10 years in the Lorain area. Survivors include his widow, four sons, two daughters, a sister and a brother.

**John B. H. Waring, M. D.,** Wilmington; George Washington University School of Medicine, 1907; aged 80; died November 24; former member of the Ohio State Medical Association. A physician for more than 50 years, Dr. Waring began private practice at Blanchester in 1921, after a number of years as a career medical officer. He moved to Wilmington in 1928. Survivors include his widow and three sons.

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# Activities of County Societies...

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### BUTLER

"Children" has been chosen as the theme for the 1965 meetings of the Butler County Medical Society, according to Dr. Brady Randolph, Hamilton orthopedist, program chairman.

Also during the program year, other age groups will receive attention through the series of lectures planned for the society, Dr. Randolph said.

The society will inaugurate its 1965 program with the Third Annual Medical Educational seminar in January. The entire seminar will be devoted to "Trauma in Children," and prominent physicians from all parts of the country will be lecturers.

"Juvenile Delinquency" will be February's topic, with Judge Benjamin Schwartz, Cincinnati juvenile court judge, as the society's guest. — *Hamilton News-Journal*.

### CLINTON

Dr. Nathan S. Hale was elected president of the Clinton County Medical Society for 1965 at the meeting Tuesday (Dec. 1) at Don McNeil's Restaurant. He will succeed Dr. Robert G. Claeys.

Other officers are Dr. Richard R. Buchanan, vice president, and Dr. Mary Boyd, secretary.

Meeting dates were changed to the fourth Tuesday of each month and the place changed to Clinton Memorial Hospital, meetings to be at 6 p. m.

Guest speaker was Dr. Alvin Hall, psychiatrist director of the Greene County Guidance Center. — *Wilmington News-Journal*.

## HAMILTON

For its December 15 meeting, the Academy of Medicine of Cincinnati had as guest speaker Dr. George Burch, professor of medicine, Tulane University School of Medicine, New Orleans, whose topic was, "New Concepts in the Management of Cardiac Disease."

## Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

### CLARK

Dr. John F. Riesser has assumed the presidency of the Clark County Medical Society, it was announced.

He succeeded Dr. George Fitzgerald during a meeting of the society Monday evening.

During the meeting Dr. David Smith was elected a delegate to the Ohio State Medical Association and Dr. Max Gerke was named an alternate.

Continuing in office are Dr. John Rechsteiner, secretary, and Dr. Wesley Knaup, treasurer. These offices are for two-year periods. — *Springfield Daily News*.

### GREENE

Dr. Charles G. Lovingood of Dayton addressed the Greene County Medical Society Thursday morning (Nov. 12) at Greene Memorial Hospital.

His topic was vascular surgery, particularly in arteriosclerotic patients. He also reviewed his experiences in this rather new field of surgery. — *Xenia Daily Gazette*.

### MONTGOMERY

The Montgomery County Medical Society and the Auxiliary sponsored a seminar at the Patterson Co-



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### Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)

#### CUYAHOGA

The annual joint meeting of the Academy of Medicine of Cleveland and the Cleveland Bar Association was held on December 8 in the Manger Hotel. A social hour and dinner was followed by the program.

Guest speaker was Carl T. Rowan, director of the U. S. Information Agency, whose topic was "Values for Living in a Thermo Nuclear Age."

Other principals in the program were Louis S. Peirce, president of the Bar Association, and Dr. Middleton H. Lambright, president of the Academy.

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#### LAKE

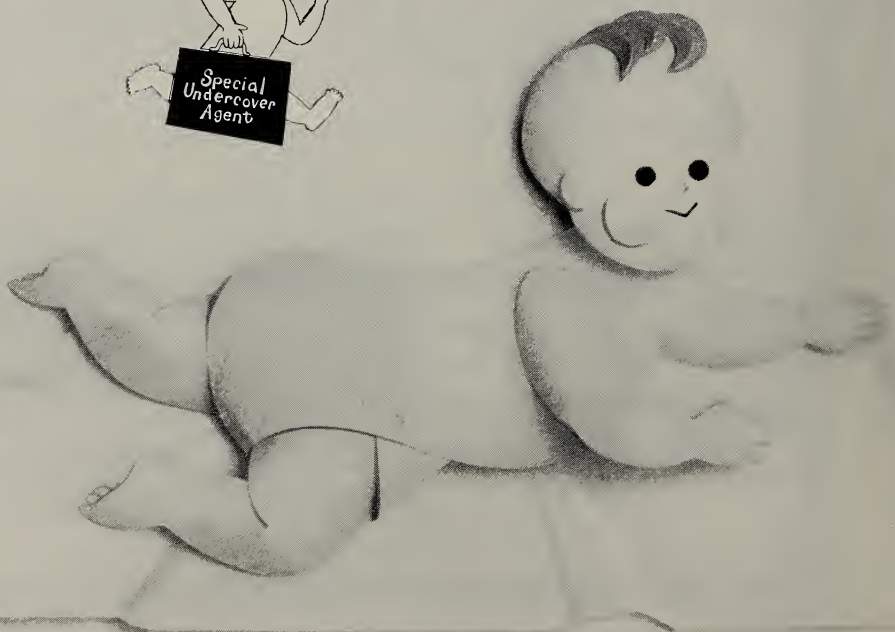
Dr. W. J. Pignolet, a Willoughby ophthalmologist, heads the Lake County Medical Society for the coming year.

Other officers named were Dr. R. W. Colopy, Painesville, vice-president, and Dr. William C. Downing, Painesville, secretary-treasurer. They were elected recently at the group's annual meeting.

Dr. Benjamin S. Park, Painesville, Lake County Health Commissioner, and Dr. Robert Smith, Painesville, represent the local society as delegates to the Ohio State Medical Association. Two Willoughby



## The case of diaper rash





physicians, Dr. A. C. Mahan and Dr. J. W. Koelliker, are alternate delegates.

Duties of censor were given to Dr. L. E. Vanags, Painesville. Mrs. Owen A. McLaren, Mentor, is executive secretary. — *The Telegraph*, Painesville.

### Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

#### COLUMBIANA

Dr. Eugene Mueller, of Salem, was guest speaker at the Columbiana County Medical Society meeting last Tuesday (Nov. 17) at the Wick Hotel in Lisbon. Dr. Mueller discussed "Inflammatory Disease of the Colon." . . .

Following a business meeting, the Society approved the application of Dr. Merle Singer, county health commissioner, for membership. A letter was read from Dr. Singer, discussing the work being done by the T. B. Clinic, with the suggestion that its personnel be left intact . . .

In other business, the Society passed a motion by Dr. Leonard S. Pritchard to appoint an advisory board, with Dr. Kolozsi as chairman, to act in an advisory capacity to the county commissioners and trustees. — *The Ledger*, Columbiana.

### TRUMBULL

The annual Christmas dinner dance of the Trumbull County Medical Society was held on December 16 at the Trumbull Country Club. The local group known as the Dixie Docs furnished music. Hosts for the occasion were members of the local anesthesiologists' society.

### Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

#### BELMONT

The Belmont County Medical Society met for dinner and a program at the Belmont Country Club on November 19. Guest speaker was Dr. Walter H. Gerwig, Jr., chief of the surgical service, Veterans Administration Hospital, Clarksburg, W. Va. His subject was "Gastric Physiologic Problems."

### Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, ZANESVILLE)

#### LICKING

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the Licking County Medical Society in cooperation with the Boy Scouts.

The first meeting of the club, held in the old nurse's home on Buena Vista St., featured a tour through Newark Hospital, sponsored by the doctors advising the group.

The club will explore all phases of medicine, and will include a trip through a university medical college, and a visit to a drug manufacturer.

Doctors interested in the group are Drs. Ralph Pickett, Gerald Ehrharc, Robert Baker, Paul Montalto, James Quinn, and Carl Petersilge. Pharmacist Lou Houston is also an advisor. Boys in the 9th grade, at least 14 years old, are eligible. — *Buckeye Lake - Thornville News*.

**Ninth District**

(COUNCILOR: GEORGE NEWTON SPEARS, IRONTON)

**WASHINGTON**

Washington County Medical Society was host Friday evening (Nov. 20) to Washington County Bar Association at a dinner dance in Castle Club. A cocktail hour preceded dinner and dancing.

Dr. and Mrs. T. P. O'Maille, Dr. and Mrs. Donald Fleming, and Dr. and Mrs. Richard Hille were the committee in charge. — *Marietta Daily Times*.

**Tenth District**

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

**FRANKLIN**

Dr. Joseph A. Bonta, 3900 Hill View Dr., was announced Saturday (Dec. 5) as president-elect of the Academy of Medicine of Columbus and Franklin County.

Dr. Bonta's election was announced during the academy's annual Christmas banquet at Columbus Plaza. He will serve during 1966.

The 1966 president-elect was presented to academy members by Dr. Homer A. Anderson, retiring president. Dr. John R. Huston will succeed Dr. Anderson this month.

Three physicians who have completed 50 years of active medical practice were honored during the banquet. They were Drs. Richard O. Adams, Wayne

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John Lambert, M. D., Medical Director, Four Winds Hospital, Washington, D. C.

Zigmond Lebensohn, M. D., Chief, Dept. of Psychiatry, Sibley Memorial, Hospital, Washington, D. C.

William Sheeley, M. D., Director of Psychiatry & Medical Practice Project of the A. P. A., Washington, D. C.

Philip Solomon, M. D., Chairman, A. P. A. Committee on Medical Practice, Boston, Mass.

**AMONG TOPICS TO BE DISCUSSED:**

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"The Physician and His Reaction to the 'Crock' "

"Newer Thoughts About the Therapy of Alcoholism"

"Medical Conditions with Psychiatric Manifestations"

"Recognition and Treatment of Depressive Reactions by Medical Practitioners"

"Treatment of Emotional States by the Medical Practitioner"

Course will be given at Jung Hotel, 1500 Canal Street, New Orleans, La. Hotel reservations to be made directly with the Jung or hotel of your choice. Registrants who would like to enjoy Mardi Gras (March 2) are urged to make hotel reservations immediately.

Guest speaker for the luncheon on March 4 will be George Burch, M. D., Henderson Professor and Chairman, Dept. of Medicine, Tulane Medical School. Subject: "Emotions and Cardiovascular Disease." Cost of luncheon included in registration fee. At the end of Friday's session, there will be a dutch treat two-hour cocktail party with George Lewis and his band from Preservation Hall entertaining.

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## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

The annual meeting of Lorain County Medical Society, preceded by a social hour and dinner at Oberlin Inn, was attended by 129 physicians and their wives.

Mrs. R. G. Thomas, Auxiliary president, asked the co-operation of all physicians in saving drug samples and used equipment for the Medical Relief project.

President John Halley expressed appreciation for the excellent co-operation he had received from the membership, and called for reports of those committees active in 1964 as follows: Education and Medical Symposium—William E. Kishman, M. D.; Grievance—Bristow C. Myers, M. D.; Audit—Ward Young, M. D.; School Health—Max L. Durfee, M. D.; Mental Health, William J. Feicks, M. D.; Cancer—A. Clair Siddall, M. D.; Lorain County Medical Foundation—J. A. Cicerella, M. D.; Resident Training—Roy E. Hayes, M. D.; Medicine and Religion—James T. Stephens, M. D.; Liaison with Lorain Co. Bar Association—Delbert A. Russell,

M. D.; Legislative—Raymond L. Shilling, M. D.; Civil Defense—Marion G. Fisher, M. D.; Blood Bank—Stanley J. Birkbeck, M. D.; Headquarters' Building—A. J. Novello, M. D.

Dr. Robert S. Van Dervort, vice-president, gave a comprehensive report on the AFA, MAA and KERR MILLS programs in response to a request from the membership at an earlier meeting.

Dr. John Halley gave highlights of the Society's progress in 1964, and secretary-treasurer William H. Miller, presented the financial statement and membership report, showing an increase of 12 members over 1963.

Following the Nominating Committee's report, given by Dr. Henry E. Kleinhenz, John W. Wherry, of Elyria, was installed as Medical Society president for 1965. Serving with him will be Max L. Durfee (Oberlin) vice-president, William H. Miller (Elyria) re-elected secretary-treasurer, and Harold E. McDonald (Elyria) as Censor. Joseph A. Cicerella (Lorain) is president-elect for 1966.

Eleventh District Councilor L. C. Meredith congratulated Dr. Halley on his successful year and commended the committee chairmen on their activity.

Kenneth O'Connor, anesthesiologist, was elected to Associate Membership in the Medical Society.

# Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Publicity Committee  
Chairman, 2442 Dorman Dr., Portsmouth

WHAT has happened to the New Year's Resolutions of yesteryear? Time was when one heard them declared in profusion—some seriously, some facetiously, some hopefully. Your reporter cannot recall hearing much of anything any more about that time-honored "tradition." Perhaps people poked too much fun at them. Yet the making of a pertinent resolution at the beginning of a New Year is not a fun game, or something without merit. It is, to my way of thinking, a step in the right direction—the indication that by "resolving" to do thus and so, we are conscious of our shortcomings and are at least making an effort to do something about them.

What has prompted all this thought on New Year's Resolutions is a quotation that appears on our National Auxiliary membership card, just recently received. It reads: "Let the helping hands of the doctor's wife reflect and enrich his dedicated service." Is it not fitting, then, that we resolve (not just for this year of 1965, but for all years to come) that our hands be truly "the helping hands of the doctor's

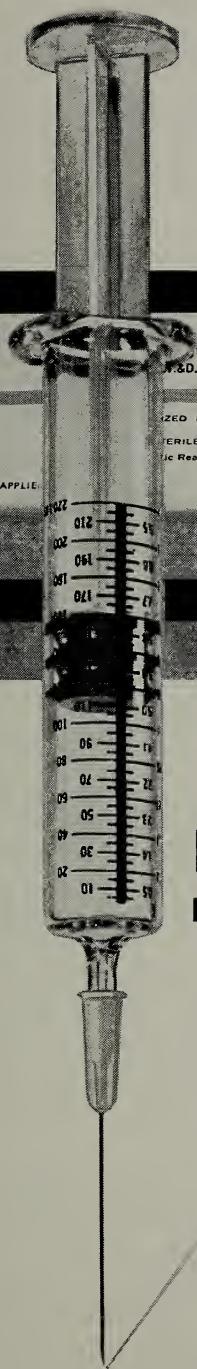
wife"? And should we not further resolve to "reflect and enrich his dedicated service" by steadfastly furthering the work and the spirit of our Auxiliary which was founded for that very purpose?

### "Open House" in Hamilton County

Several members of the Hamilton County Auxiliary are graciously opening their homes this year for the monthly meetings of the Intern-Resident Wives Club. Besides meeting for companionship, this group carries on several charity efforts and makes an annual contribution to the Cincinnati General Hospital Auxiliary. The money comes from the annual April fashion show and bridge party. The first meeting of the Intern-Resident Wives Club was held at the home of Mrs. Robert Krone, a past-president of the Hamilton County Auxiliary. In November, the hostess was Mrs. Edward J. Bender. Dr. and Mrs. Bender are collectors of antique silver and the young wives were privileged to view this most unusual and beautiful collection.

Other doctors' wives who will hostess the club this





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year include: Mrs. Raymond L. Hilsinger, Mrs. Joseph Lindner, Mrs. C. B. DeCourcy and Mrs. Harold G. Reineke.

The November meeting of the Hamilton Auxiliary highlighted a program by the Cincinnati Civic Ballet Company. Mr. Oleg Sabline presented six soloists from the Ballet's senior company and an ensemble of 12 dancers from the junior company in a performance complete with costumes and music. Mr. Sabline is lecturer in ballet at the College Conservatory of Music and with his ballerina wife, Mlle. Tania Karina, is co-artistic director of the Civic Ballet. Mrs. Donald R. Thomas was chairman of hospitality for the occasion which was open to members of the auxiliary and their guests. Mrs. John L. Thinnies served as vice-chairman and Mrs. Robert J. Kalthoff as program chairman.

A feature of the group's Victorian Ball in December was a sleigh, gilded and decorated with roses by Mrs. Charles Feuss, which received toys and other Christmas gifts for the children at Longview Hospital and Hillcrest School. There was even a telephone answering service at the Ball, under the co-chairmanship of Mrs. Ernest Rolfes and Mrs. Richard Boisman, as practical and worthwhile an adjunct as we've ever come across! Mrs. John Molloy Glenn was chairman of the Victorian Ball and Mrs. Leonard Wellen Kuehnle, vice-chairman. Mrs. Quintin DeBrosse served as invitations chairman. It was all for Hamilton Auxiliary's education and philanthropy fund.

#### Cheers for Clermont County Auxiliary

Our newest addition to the ranks of county auxiliaries is off to an excellent start. The group held its first meeting of the year in October at the home of Mrs. Carl Minning. "The Fable of the Foiled Physician," a film from AMPAC, was shown, following which Mrs. Phillips Greene discussed "Political Effectiveness." Mrs. Albert Van Sickle, president, presided at the business meeting at which a resolution was passed to give all possible help to the Clermont County Hospital. One of the Auxiliary's first projects is for AMA-ERF—the sale of Christmas cards under the chairmanship of Mrs. Franklin Lowe.

In November, the group met at the home of Mrs. Gordon Schulze. "A Good Right Arm" was read by Mrs. Paul Baurichter and Mrs. Martin Saidleman. It is a one-act play giving the history of the national auxiliary. And on December 19, the Clermont group held a joint dinner meeting with their husbands at the home of Dr. and Mrs. Charles Simmons of Bethel. The theme was "Our Husbands Pay" and the proceeds from the dinner were turned over to the Retarded Children's School.

#### Greene County Auxiliary

This group met in September with Mrs. John D. Dickie, state president, at a luncheon meeting at the

Red Brick Tavern in Lafayette. Mrs. Dickie discussed the national convention and the emphasis of Mrs. William H. Evans, national president, on international health. The October meeting was a luncheon at Antioch Inn in Yellow Springs, with Dr. Kenneth Hunt, administrator of Glen Helen, as guest speaker. The November meeting was a tea at the home of Mrs. Harvey McClellan in Xenia. Dr. Mary Agna, health commissioner of Greene County, was guest speaker and discussed the department's Homemakers' Service.

This Auxiliary sponsors two nurses' scholarships a year. The group receives funds from two vending machines at Greene Memorial Hospital which are now being used to help furnish a new doctors' lounge. Funds for other projects are being raised by the sale of candy. Contributions for AMA-ERF are coming from the sale of stationery, Christmas cards and bracelets. The Greene County Auxiliary has also taken out an organizational membership in the Project Hope. As if all that weren't enough, the group is helping with the expense of a dinner to honor local foster parents. Which proves that a small Auxiliary can come up with a lot of big things!

#### Scioto Auxiliary and Authors' Luncheon

Close to two hundred people bought tickets for the recent Authors' Luncheon at the Elks City Club Auditorium in Portsmouth. The occasion served a dual purpose: to sponsor a cultural activity and to help raise money for the group's AMA-ERF project. The unusual program was made possible through the cooperation of Marting's Book Department which arranged for the presence of Jesse Stuart, Frank Edwards and Mrs. Doris Miller.

Mr. Stuart discussed his latest book, *Save Every Lamb*. He complimented the local doctors' wives on their initiative in promoting a books - authors program, a first, to his knowledge, in Ohio. He is the author of many popular novels and is also a well-known poet who has received national acclaim. Frank Edwards, the second speaker, was a pioneer broadcaster and news analyst before becoming an author. He presented several excerpts from his writings. Mrs. Doris Miller, newspaper reporter and columnist, discussed different styles of writing and the evaluation of literature as considered by the critics.

The occasion was also the twenty-fourth birthday of the local group. Its first president, Mrs. Samuel L. Meltzer, highlighted the Auxiliary's activities since its inception in October, 1940. It was an excellent opportunity to present the Auxiliary "story" before a lay public.

#### Happy New Year!

On behalf of your state officers . . . "The New Year like an Infant Heir to the whole World" (Charles Dickens said it!)



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## COMMITTEES

**Committee on Education**—Thomas E. Rardin, Columbus, Chairman (1966); Thomas S. Brownell, Akron (1969); John G. Sholl, Cleveland (1968); Elmer R. Maurer, Cincinnati (1967); Clyde W. Muter, Warren (1965).

**Judicial and Professional Relations Committee**—Frank F. A. Rawling, Toledo, Chairman (1968); Chester A. Allen, Portsmouth (1969); Thomas R. Curran, Columbus (1967); Paul A. Mielcarek, Cleveland (1966); William H. Crays, Springfield (1965).

**Committee on Public Relations and Economics**—Frederick P. Osgood, Toledo, Chairman (1969); John H. Budd, Cleveland (1968); John J. Cranley, Jr., Cincinnati (1967); Horace B. Davidson, Columbus (1966); James T. Stephens, Oberlin (1965).

**Committee on Scientific Work**—Maurice A. Schnitker, Toledo Chairman (1965); John D. Battle, Jr., Cleveland (1969); Harold Schneider, Cincinnati (1969); Isador Miller, Urbana (1968); Samuel Saslaw, Columbus (1968); William Hamelberg, Columbus (1967); F. A. Simeone, Cleveland (1967); Ralph K. Ramsayer, Canton (1966); G. Douglas Talbot, Dayton (1966); Richard W. Avery, Seville (1965).

**Committee on Care of the Aging**—Charles W. Stertzbach, Youngstown, Chairman; James O. Barr, Chagrin Falls; Dwight L. Becker, Lima; Robert A. Borden, Fremont; Edwin W. Burnes, Van Wert; Lowell O. Dillon, Columbus; Philip T. Doughten, New Philadelphia; Robert B. Elliott, Ada; George T. Harding, Sr., Worthington; Roger E. Heering, Columbus; James L. Henry, Grove City; Marion R. Huston, Millersburg; John S. Kozy, Toledo; Francis M. Lenhart, Defiance; Harold E. McDonald, Elyria; Elliott W. Schlike, Springfield; Clarence V. Smith, Canton; Joseph B. Stocklen, Cleveland; Robert E. Swank, Chillicothe; Don P. VanDyke, Kent; William M. Wells, Newark; Roger Williams, Columbus.

**Committee on Cancer**—Arthur G. James, Columbus, Chairman; Thomas D. Allison, Lima; William J. Flynn, Youngstown; Douglas P. Graf, Cincinnati; Chester R. Lulenski, Cleveland; William A. Newton, Jr., Columbus; W. D. Nusbaum, Lancaster; Benjamin S. Park, Fainesville; Arthur E. Rappoport, Youngstown; Carl A. Wilzbach, Cincinnati; William P. Yahraus, Canton.

**Committee on Eye Care**—Arthur D. Collins, Cleveland, Chairman; Martin J. Cook, Springfield; Thomas L. Edwards, Lima; Robert H. Magnuson, Columbus; Russell J. Nicholl, Cleveland; Claude S. Perry, Columbus; Norman W. Pinschmidt, Gallipolis; Barnett R. Sakler, Cincinnati; Robert L. Willard, Toledo.

**Committee on Hospital Relations**—William R. Schultz, Wooster, Chairman; Russell H. Barnes, Mansfield; L. Fred Bissell, Aurora; Robert M. Craig, Dayton; John V. Emery, Willard; Harvey C. Gunderson, Toledo; Philip B. Hardymon, Columbus; James C. McLarnan, Mt. Vernon; Ben V. Myers, Elyria; Russell Rizzo, Cleveland; Robert A. Tennant, Middletown; V. William Wagner, Port Clinton; William A. White, Canton.

**Committee on Laboratory Medicine**—Horace B. Davidson, Columbus, Chairman; William H. Benham, Columbus; John B. Hazard, Cleveland; Melvin Oosting, Dayton; Arthur E. Rappoport, Youngstown; William B. Smith, Zanesville; Philip B. Wasserman, Cincinnati.

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**Committee on Maternal Health**—Anthony Ruppberg, Columbus, Chairman; Otis G. Austin, Medina; Raymond E. Barker, Columbus; William D. Beasley, Springfield; Keith R. Brandeberry, Gallipolis; Thomas E. Byrne, Mentor; C. Raymond Crawley, Dover; Mel A. Davis, Columbus; Marion F. Detrick, Jr., Findlay; John P. Garvin, Columbus; Robert A. Heilman, Columbus; John F. Hillabrand, Toledo; Robert E. Johnstone, Cincinnati; Albert A. Kunnen, Dayton; Reuben R. Maier, Cleveland; James F. Morton, Zanesville; Ralph K. Ramsayer, Canton; Robert E. Swank, Chillicothe; Densmore Thomas, Warren; Robert S. VanDervort, Elyria.

**Committee on Medicine and Religion**—George W. Petznick, Cleveland, Chairman; John D. Albertson, Lima; J. H. Carson, Martins Ferry; Eugene F. Damstra, Dayton; Francis M. Lenhart, Defiance; Ralph W. Lewis, Portsmouth; J. Kenneth Potter, Cleveland; Charles A. Sebastian, Cincinnati; John R. Seesholtz, Canton; William B. Smith, Zanesville; James T. Stephens, Oberlin; Donald J. Vincent, Columbus.

**Committee on Mental Health**—Arnold Allen, Dayton, Chairman; Calvin L. Baker, Columbus; E. H. Crawfis, Cleveland; Max D. Graves, Springfield; Charles W. Harding, Worthington; Henry L. Hartman, Toledo; J. Robert Hawkins, Cincinnati; Nathan B. Kalb, Lima; Philip E. Piker, Cincinnati; Thomas E. Rardin, Columbus; Philip C. Rond, Columbus; Jack Schreiber, Canfield; Victor M. Victoroff, Cleveland; John A. Wheldon, Columbus.

**Committee on Disaster Medical Care**—Wendell A. Butcher, Columbus, Chairman; Thomas D. Allison, Lima; Nino M. Camardese, Norwalk; Drew L. Davies, Columbus; John H. Davis, Cleveland; Gregory G. Floridis, Dayton; Robert S. Heidt, Cincinnati; Thomas W. Morgan, Gallipolis; Sterling W. Obenour, Jr., Zanesville; Vol K. Philips, Columbus; Earl Rosenblum, Steubenville; William S. Rothermel, Canton; Robert B. Strother, Toledo; Elden C. Weckesser, Cleveland; Ward V. B. Young, Elyria.

**Military Advisory Committee**—Drew L. Davies, Columbus, Chairman; A. A. Brindley, Maumee; Ralph G. Carothers, Cincinnati; Homer D. Cassel, Dayton; Henry A. Crawford, Cleveland; Walter L. Cruise, Zanesville; Charles R. Keller, Mansfield; Edward L. Montgomery, Circleville; Frank T. Moore, Akron; Ralph Lewis, Portsmouth; Earl Rosenblum, Steubenville.

**Committee on Occupational Health**—Rex H. Wilson, Akron, Chairman; Drew J. Arnold, Columbus; William W. Davis, Columbus; Bertram D. Dinman, Columbus; Winfred M. Dowlin, Canton; Harold M. James, Dayton; Robert A. Kehoe, Cincinnati; H. W. Lawrence, Cincinnati; Daniel M. Murphy, Marion; George W. Wright, Cleveland; R. P. Worstell, Columbus.



## STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

**Committee on Poison Control**—John A. Norman, Akron, Chairman; William G. Gilger, Cleveland; Mason S. Jones, Dayton; James H. Bahrenburg, Canton; Edward V. Turner, Columbus; William M. Wallace, Cleveland; Hugh Wellmeier, Piqua.

**Committee on Radiation**—Charles M. Barrett, Cincinnati, Chairman; Eldred B. Heisel, Columbus; George F. Jones, Lancaster; Carey B. Paul, Jr., Columbus; Thomas C. Pomeroy, Columbus; Denis A. Radefeld, Lorain; Eugene L. Saenger, Cincinnati; Robert E. Schulz, Wooster; John P. Storaasli, Cleveland; Robert P. Ulrich, Troy; Robert L. Wall, Columbus; John Robert Yoder, Toledo; James G. Kereakes, Ph.D. (Advisory Member, Special Consultant), Cincinnati.

**Committee on Rural Health**—Robert E. Reiheld, Orrville, Chairman; Chester J. Brian, Eaton; J. Martin Byers, Greenfield; Walter A. Campbell, Coshocton; E. Joel Davis, East Canton; Victor R. Frederick, Urbana; Benjamin W. Gilliotte, Zanesville; J. L. Hammon, West Milton; Jasper M. Hedges, Circleville; Luther W. High, Millersburg; John R. Polsley, North Lewisburg; Leonard S. Pritchard, Columbiana; Harold C. Smith, Van Wert; George N. Spears, Ironton; Kenneth W. Taylor, Pickerington; Edmond K. Yantes, Wilmington.

**Committee on School Health**—Charles H. McMullen, Loudonville, Chairman; Margaret E. Belt, Lima; Walter Felson, Greenfield; Paul D. Hahn, New Philadelphia; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Lawrence L. Maggiano, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Albert E. Thielen, Cincinnati; Homer B. Thomas, Gallipolis.

**Committee on Traffic Safety**—N. J. Giannestras, Cincinnati, Chairman; Howard W. Brettell, Steubenville; Drew L. Davies, Columbus; Clark M. Dougherty, New Philadelphia; Wesley L. Furste, Columbus; Thomas W. Morgan, Gallipolis; Lester G. Parker, Sandusky; Thomas N. Quilter, Marion; John F. Tilotson, Lima; Robert C. Waltz, Cleveland; Paul L. Weygandt, Akron; Robert E. Zipf, Dayton.

**Committee on Workmen's Compensation**—H. P. Worstell, Columbus, Chairman; A. L. Berndt, Portsmouth; Thomas H. Brown, Jr., Toledo; Charles A. Browning, Jr., Bellefontaine; Oscar W. Clarke, Gallipolis; Frederick A. Flory, Columbus; Clyde O. Hurst, Portsmouth; Edmund F. Ley, Tiffin; Joseph Lindner, Sr., Cincinnati; Paul A. Mielcarek, Cleveland; James G. Roberts, Akron; George L. Sackett, Sr., Painesville; Joseph H. Shepard, Columbus; Rex H. Wilson, Akron; James N. Wychgel, Cleveland.

### DELEGATES AND ALTERNATES

**Delegates and Alternates to the American Medical Association**—George W. Petznick, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Theodore L. Light, Dayton; Kenneth D. Arn, Dayton, alternate; Edmond K. Yantes, Wilmington; Harry K. Hines, Cincinnati, alternate; John H. Budd, Cleveland; P. John Robeck, Cleveland, alternate; Richard L. Meiling, Columbus; Robert E. Tschantz, Canton, alternate; Paul F. Orr, Perrysburg; Frederick P. Osgood, Toledo, alternate; Charles A. Sebastian, Cincinnati; J. Robert Hudson, Cincinnati, alternate; Edwin H. Artman, Chillicothe; Philip B. Hardyman, Columbus, alternate.

## COUNTY SOCIETIES' OFFICERS AND MEETING DATES

### First District

Councilor: Robert E. Howard, Cincinnati 43202  
2600 Union Central Bldg.

**ADAMS**—Hazel L. Sproull, President, 113 E. Mulberry St., West Union; Kenneth C. Jee, Secretary, Winchester.

**BROWN**—Carl A. Liebig, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown.

**BUTLER**—Marvin J. Russell, President, Mercy Hospital, Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. Third St., Hamilton. 3rd Wednesday, monthly.

**CLERMONT**—Albert Van Sickle, President, Clermont County Health Dept., Batavia; Phillips F. Greene, Secretary, Box 509, Rt. #1, New Richmond. 3rd Wednesday, monthly.

**CLINTON**—Robert G. Clays, President, 12 N. Lincoln St., Wilmington; Mary Ranz Boyd, Secretary, Box 629, Wilmington. 1st Tuesday, monthly.

**HAMILTON**—John J. Cranley, President, 311 Howell Ave., Cincinnati 20; Mr. Edward F. Willenborg, Exec. Secy., 320 Broadway, Cincinnati 2. 3rd Tuesday monthly, September through May.

**HIGHLAND**—Walter Felson, President, 357 South St., Greenfield; Thomas Jones, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

**WARREN**—Dale D. Hubbard, President, 116 Warren Ave., Franklin; D. Paul Ward, Secretary, Box 18, Pleasant Plain. 2nd Tuesday, monthly.

### Second District

Councilor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

**CHAMPAIGN**—Francis R. Grogan, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.

**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, 29 East Wood Street, Versailles. 3rd Tuesday, monthly.

**GREENE**—Norman G. Linton, President, Jamestown; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Paul Troup, President, 2235 Philadelphia Dr., Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—Willard C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

**SHELBY**—George J. Schroer, President, 322 Second Ave., Sidney; Alfonso Kisielius, Secretary, Ohio Building, Sidney. 2nd Tuesday, monthly.

### Third District

Councilor: Frederick T. Merchant, Marion 43301  
1051 Harding Memorial Pky.

**ALLEN**—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima. 3rd Tuesday, monthly, except June, July and August.

**AUGLAIZE**—James R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville. Called meetings.

**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.

**HANCOCK**—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.

**HARDIN**—Glen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center. 2nd Tuesday, monthly, except June, July and August.

**LOGAN**—Charles L. Barrett, President, 119 S. Madriver St., Bellefontaine; George Gensemer, Secretary, 834 North Main St., Bellefontaine. 1st Friday monthly except July, August.

**MARION**—Paul E. Lyon, President, 1051 Harding Memorial Parkway, Marion; Lester Wall, Secretary, 317 S. Main Street, Marion. 1st Tuesday, monthly.

**MERCER**—Joseph A. Skaggs, President, 119 E. Fayette, Celina; R. Duane Bradrick, Secretary, 225 S. Main St., Rockford. 3rd Thursday, monthly.

**SENECA**—O. G. Burkart, Jr., President, 19 E. Perry St., Tiffin; Olgierd C. Carlo, Secretary, 53 Clay St., Tiffin. Every third Tuesday.

**VAN WERT**—Joseph R. Kreischer, President, 115 High St., Convoy; Griff W. Bilbro, Secretary, Van Wert Co. Hospital, Van Wert. 1st Friday, monthly.

**WYANDOT**—Donald P. Smith, President, Sycamore; Herschel A. Rhodes, Secretary, 777 N. Sandusky Ave., Upper Sandusky. 2nd Tuesday, monthly.

### Fourth District

Councilor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

**DEFIANCE**—Richard A. Cunningham, President, 509 Fourth St., Defiance; William S. Busted, Secretary, 509 Fourth St., Defiance. 1st Saturday, monthly.

**FULTON**—William J. Neal, President, 224 N. Defiance, Archbold; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon. 2nd Tuesday quarterly, March, June, September and December.

**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, Heller Memorial Hospital, Napoleon.

**LUCAS**—Gordon M. Todd, President, 2005 Orchard Rd., Toledo 6; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday, monthly, except July and August.

**OTTAWA**—Robert Reeves, President, 118 Church St., Oak Harbor; Kenneth L. Akins, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Laura at Merrin, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. 3rd Wednesday, monthly.

**PUTNAM**—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Luginbuhl, Secretary, Pandora. 1st Tuesday monthly.

**SANDUSKY**—Thaddeus Stabholz, President, 319 Birchard Ave., Fremont; John L. Zimmerman, Secretary, Memorial Hospital, Fremont. 3rd Wednesday, monthly.

**WILLIAMS**—Robert G. Sheperd, President, 104 N. Main St., West Unity; Howard J. Luxan, Secretary, Masonic Temple, Montpelier.

**WOOD**—Louis P. Baldoni, President, 138 E. Front St., Perrysburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

## Fifth District

Councilor: P. John Robecheck, Cleveland 44106  
10525 Carnegie Ave.

**ASHTABULA**—Albin F. Urankar, President, Ashtabula General Hospital, 2420 Lake Ave., Ashtabula; William F. Davis, Secretary, 2125 Lake Ave., Ashtabula. 2nd Tuesday, monthly.

**CUYAHOGA**—Middleton H. Lambright, Jr., President, 10616 Euclid Avenue, Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland, 6.

**GEAUGA**—Raymond I. Smith, President, P.O. Box 203, Chardon; Bruce F. Andreas, Secretary, 400 Downing Dr., Chardon. 2nd Friday, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7403 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

## Sixth District

Councilor: Edwin R. Westbrook, Warren  
438 North Park Ave.

**COLUMBIANA**—Janis Lauva, President, 338 Main St., Wells; Edith S. Gilmore, P.O. Box 12, East Liverpool. 3rd Tuesday, monthly.

**MAHONING**—Jack Schreiber, President, Doctors Park, Canfield; Mr. Howard C. Rempes, Jr., Exec. Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown. 3rd Tuesday, monthly, except June, July and August.

**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARK**—G. O. Thompson, President, 307 City Savings Bldg., Alliance; Mr. J. H. Austin, Exec. Secretary, 405 Fourth St., Canton. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—Ralph E. Meacham, President, 1101 Youngstown Rd., Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

## Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry  
30 S. 4th St.

**BELMONT**—Homer E. Ring, President, 3205 Belmont St., Belaire; Bertha M. Joseph, Secretary, 100 South 4th St., Martins Ferry. 3rd Thursday, monthly.

**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Ateshon, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCTON**—Walker A. Campbell, President, 1223 Sleepy Hollow, Coshocton; Harold W. Lear, Secretary, 133 South Fourth St., Coshocton. 2nd Tuesday, monthly.

**HARRISON**—George E. Henderson, President, Main St., New Athens; Charles D. Evans, Jr., Secretary, 420 E. Market St., Cadiz. Quarterly meetings held March, June, September and December.

**JEFFERSON**—C. W. Lighthizer, President, 511 North Fourth St., Steubenville; Crist G. Strovilas, Secretary, Room 200, Union Savings Bank Bldg., Toronto. 2nd Tuesday, monthly.

**MONROE**—Ronald E. Christman, Jr., President, 104 N. Sycamore St., Woodfield; Byron Gillespie, Secretary, South Main St., Woodfield.

**TUSCARAWAS**—C. Raymond Crawley, President, 232 West Third St., Dover; James R. Martin, Secretary, 404 N. Walnut St., Dover. 2nd Thursday, monthly.

## Eighth District

Councilor: Robert C. Beardsley, Zanesville  
2236 Maple Ave.

**ATHENS**—Robert E. Main, President, 400 East State Street, Athens; Lester A. Hamilton, Secretary, 400 East State Street, Athens. 2nd Tuesday at noon, monthly.

**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hodsdon, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—George M. Wyatt, President, 1315 Westchester Dr., Cambridge; Darell J. Smith, Secretary, Rt. 3, Medical Arts Bldg., Cambridge. 1st Tuesday, monthly, except June, July and August.

**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta. Called meetings.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

**NOBLE**—Frederick M. Cox, President, 1st National Bank Bldg., Caldwell; Edward G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

**PERRY**—Alton J. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, West Main St., Somerset. 3rd Thursday, every third month.

**WASHINGTON**—Tuathal Patrick O'Maille, President, Marietta Memorial Hospital, Marietta; Richard R. Hille, Secretary, 323 Second St., Marietta.

## Ninth District

Councilor: George Newton Spears, Ironton  
2213 S. 9th St.

**GALLIA**—Isom C. Walker, Jr., M.D., President, Holzer Hospital, Gallipolis; Gene H. Abels, Secretary, Holzer Hospital, Gallipolis. Quarterly meetings.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Books, Secretary, Route 3, Logan. Quarterly meetings.

**JACKSON**—Carl J. Greever, President, 25 E. South St., Jackson; John E. MacLennan, Secretary, Oak Hill Hospital, Oak Hill. Called meetings.

**LAWRENCE**—Dean F. Massie, President, 2323 S. 7th St., Ironton; George Newton Spears, Secretary, 422 S. 6th St., Ironton. Called meetings.

**MEIGS**—Selim J. Blazewicz, President 112½ E. Main St., Pomeroy; Roger P. Daniels, Secretary, Pomeroy. Called meetings.

**PIKE**—Kenneth A. Wilkinson, President, 330 E. North St., Waverly; Albert Shrader, Secretary, E. Water St., Waverly. 1st Tuesday, monthly.

**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spence K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

## Tenth District

Councilor: Richard L. Fulton, Columbus 43212  
1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

**FAYETTE**—James E. Rose, President, 1049 Washington Ave., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H.

**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Clinton W. Trott, President, Medical Arts Building, Mt. Vernon; Raymond S. Lord, Secretary, Knox Medical Associates, Columbus Road, Fredericktown.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, 210 N. Main St., London. 2nd Wednesday monthly.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Robert H. McCoy, President, 125 N. Pickaway St., Circleville; E. L. Montgomery, Secretary, 108 Seyfert Ave., Circleville. 1st Friday, monthly.

**ROSS**—David McKell, President, 60 Central Center, Chillicothe; Joseph McKell, Secretary, 174 West Main St., Chillicothe. 1st Thursday, monthly.

**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of Feb., April, Oct. and Dec.

## Eleventh District

Councilor: L. C. Meredith, Jr., Elyria  
205 Elyria Block

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Clem Chalfant, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.

**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P.O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

**HOLMES**—Owen W. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.

**HURON**—Nina M. Carradise, President, 12 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday, every other month.

**LORAIN**—John Halley, President, 328 Main St., Vermilion; Mrs. C. Ruth Zealley, Exec. Secretary, 428 West Avenue, Elyria. 2nd Tuesday, monthly.

**MEDINA**—Richard C. Gosh, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Carroll E. Damron, President, 480 Glessner Ave., Mansfield; C. J. Shames, Secretary, 74 Wood St., Mansfield. 3rd Thursday, monthly.

**WAYNE**—Robert E. Reiheld, President, Orrville; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday of January, March, May, Sept., Nov., and Dec.

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Dr. Robert Kuba, Uhrichsville, was guest speaker at a meeting of the Uhrichsville Quest Club, where he discussed Medicare.

## JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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"Aha!" is what you'll say time and time again when you prescribe Dilaudid® Cough Syrup for the management of persistent, racking, unproductive coughs.

Dilaudid (hydromorphone) gives a degree of antitussive action that ordinary codeine and codeine-like substances cannot match. Also, glyceryl guaiacolate provides superior expectorant action.

Furthermore, you have more *complete control of the cough*. The patient needs your written prescription whenever coughs become troublesome and must be relieved.

The usual therapeutic dose is one teaspoonful (5 ml.) repeated every three to four hours. The dose for children should be adjusted according to age and body weight. Each 5 ml. of Dilaudid Cough Syrup contains 1 mg. hydromorphone and 100 mg. glyceryl guaiacolate in a pleasant-tasting, peach-flavored vehicle containing 5% alcohol. Subject to Federal Narcotic Regulations.

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*\*according to Webster, satisfaction...pleasure...triumph.*

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KNOLL PHARMACEUTICAL COMPANY • ORANGE, NEW JERSEY

DILCS 641

# When the Doctor Dies...

## A Check List for Survivors; Things To Do Immediately, With Suggested Procedures Toward Settlement of Estate

THE death of a physician, especially if it is untimely or unexpected, leaves a multitude of details for the widow or other survivors to handle quickly and efficiently. To ease the task for survivors of its members, the Academy of Medicine of Cleveland has published a pamphlet containing a listing of details that most families face, with suggestions for dealing with some of the complex problems.

Incidentally, the list may be useful to the physician who wishes to check to make sure that his affairs are in order.

Following is the check list as published by the Cleveland Academy, with slight modifications:

\* \* \*

It should be pointed out that many of the items appearing below are matters which technically will be the professional responsibility of Executor (if the Doctor died with a Will) or the Administrator (if the Doctor died without a Will). However, the information contained herein may prove to be helpful not only to the person having this responsibility but also to the Doctor's survivor. It is recommended that the survivor discuss the contents of this pamphlet with the Executor or Administrator of the Doctor's estate as soon as possible.

The survivor will probably need to know these items:

1. Social Security Number or Taxpayer's Identification Number
2. Accountant or Estate Planner: Name, address, phone number
3. Attorney: Name, address, phone number
4. Employee(s): Name(s), address(es), phone number(s), details of termination of services
5. Insurance Agent (and/or Estate Planning Manager): Name, address, phone number
6. Stockbroker: Name, address, phone number
7. Trust (if established): Name of Trustee, address, phone number, name of bank's representative, phone, extension if the trustee is a bank
8. Will: Location, location of any codicils
9. Home: Location of deed, mortgage papers, etc.
10. Office: Location of deed or lease, mortgage papers, duration of lease or mortgage, provision for settling in event of death
11. Other real estate: Location(s) of deed(s) or mortgage paper(s)
12. Life Insurance: Location of policies
13. Other Insurance: Location of policies
14. Temporary coverage of the Practice: Name, address and phone number of an associate
15. Securities: Location of policies
16. Current unpaid bills: Location
17. Outstanding obligations: Notes, mortgages, pledges, charge accounts, credit checking accounts, etc. Details
18. Safety Deposit Box(es): Location(s) number(s), locations of keys
19. Savings Accounts(s): Locations(s) of pass-book(s)
20. Checking Account(s): Location(s), location(s) of checkbook(s)
21. Financial Records: Location
22. Cash: Location of receipts, unbanked cash, source of cash for immediate needs
23. Tax Information: Location
24. Accounts receivable: Location, the Doctor's views on collecting current and delinquent bills
25. Notes, loans, mortgages, etc., due from others: Location of items
26. Notifying patients: Method preferred by the doctor, location of appointment book
27. Notification: Hospital(s) — (Administrator), phone numbers; colleagues, phone numbers; Societies, etc., phone numbers
28. Veterans Administration: Branch of Service, date of discharge, service number, VA number(s), location of discharge papers
29. Blue Cross, etc.: Policy numbers of Blue Cross, Blue Shield and other Health Insurance (see later discussion)
30. Narcotics: Location of drugs, tax stamp, narcotics ledger, narcotics order book
31. Equipment (major): Purchase price, sales outlet
32. The Doctor's views on disposition of property, securities, anticipated income, etc.
33. Birth and Marriage Records: Location
34. Citizenship Papers (if applicable): Location

In addition to the foregoing, but subject to the rights and duties of the Executor or Administrator, survivors may become involved with the following:

*(Continued on Page 102)*



# kills Haemophilus influenzae in respiratory infections



Electron micrograph of normal *H. influenzae* organism.



Electron micrograph of *H. influenzae* after a 2-hour exposure to a therapeutic ( $8\gamma/\text{ml.}$ ) dose of PENBRITIN (ampicillin).

## *New broad-spectrum penicillin:*

- most active antibiotic against *Haemophilus influenzae*<sup>1-3</sup>—a major pathogen in chronic bronchitis and respiratory infections in children
- demonstrated clinical efficacy and safety in chronic bronchitis<sup>4-10</sup>
- more effective than tetracycline in reducing sputum in chronic bronchitis<sup>5</sup>

**Usual Adult Dosage:** 250 mg. every six hours. **Usual Dosage for Children**—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

**Contraindications:** (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci or other penicillinase-producing organisms.

**Side Effects:** Mild effects, such as skin rashes, diarrhea, nausea and vomiting, have occasionally appeared.

**Precautions:** As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

**Supplied:** No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

**References:** 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. i:1159 (April 28) 1962. 2. Ivler, D., et al.: Abstracts, Third Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stewart, G. T.: Pharmakotherapie 1:197, 1963. (Progress in Drug Therapy). 4. Grant, I. W. B., et al.: Brit. M. J. ii:482 (Aug. 18) 1962. 5. Millard, F. J. C., and Batten, J. C.: Brit. M. J. i:644 (March 9) 1963. 6. Oswald, N. C.: Postgrad. Med. 35:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit. J. Clin. Pract. 17:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Thorax 19:298, 1964. 9. May, J. R., et al.: Lancet ii:444 (Aug. 29) 1964. 10. Pines, A.: Lancet ii:445 (Aug. 29) 1964.

KILLS BACTERIA...DOES NOT JUST SUPPRESS THEM

# PENBRITIN®

Brand of Ampicillin

AYERST LABORATORIES, NEW YORK, N.Y.

Distributors for  
BEECHAM RESEARCH LABORATORIES INC.

- I. Probate of the Will: The attorney will do this.
- II. Disposition of narcotics, drug samples and medications.
  - A. Narcotics remaining:
    1. Obtain authorization of Internal Revenue to sell to a doctor or to a drugstore.
    2. Return unbroken packages to wholesale drug firm.
    3. Turn in to District Supervisor, Bureau of Narcotics, 602 Federal Bldg., Detroit 26, Michigan. No reimbursement is made.
  - B. Narcotics Tax Stamp must be returned to the Internal Revenue Service, Special Tax Unit.
  - C. Narcotics Order Book also must be returned to the Internal Revenue Service, Special Tax Unit.
  - D. Narcotics Ledger must be retained for two years.
  - E. Disposition of drug samples and other medications:
    1. Do not throw away unless opened, unlabeled, or deteriorated.
    2. Any purchased drugs may be returnable for refund if unopened. Perhaps the Doctor's supplier or pharmacist would be kind enough to help in this matter.
    3. The Woman's Auxiliaries in many counties will distribute all drugs turned in to appropriate charitable organizations.
- III. Patient Records:
  - A. These are important and confidential records which should be carefully preserved.
  - B. The contents of such records should be disclosed to another physician only if the patient so requests. Such a request should be in writing and should be retained with the records. Normally, the records are confidential and diagnostic information in them should not be disclosed directly to the patient because of the risk that he might misinterpret them.
  - C. All patients' medical records should be kept for a minimum of 10 years. Records of patients who were minors when treated should be preserved until two years after the patient reaches 21. Where possible records should be kept for 25 years. Financial records should be kept for seven years which is the statute of limitation on such information.
- IV. Telephone: If there is an answering service, this can be a very helpful way of notifying patients of the Doctor's death with possible suggestions regarding their continued care. It is suggested that this service be retained for at least a month.
- V. Notifying patients: Perhaps a simple sign on the office door "Call ..... (office phone number)" will relieve the family of the burden of con-

tact with most of the patients and the answering service can take care of the matter.

If the physician's secretary is retained temporarily, she might perform this service by being present during usual office hours. She also could notify patients with future appointments during this time.

VI. Taxes: The accountant and/or attorney should take care of all of this in connection with the financial records.

VII. Stopping advertising mail: It may take a year for knowledge of the Doctor's death to reach all the mailing lists; there is no central clearing office. You may perhaps choose to let it run out in this fashion, or you may write "Deceased return to sender" on each piece and mail it back. While the latter course might entail some effort initially, it will rapidly and effectively cut off the flow.

VIII. Insurance Agent and/or Trustee: A preliminary brief conference might be in order to settle the question of immediate funds, documents to be located, and arrangements for a later, detailed conference. Prompt notification of such people is important.

IX. Consideration of Sale of Practice: If the practice is to be sold, with or without real estate, relatively rapid action is advised, for it will quickly lose value. It can be advertised in the local *Bulletin*, *Ohio State Medical Journal*, the *Journal of the American Medical Association*, etc. There are also agencies which specialize in such matters. Professional status of physicians who are prospective buyers can be verified with the County Medical Society or the OSMA office in Columbus.

X. Real Estate: Except for practice-connected real estate, a hasty decision on sale or retention is not advised. It is hoped that the doctor has made known his views on this subject.

XI. Temporary coverage of patients:

- A. Some arrangement with a colleague should be made immediately as regards patients in the hospital.
- B. While not required, it would be a courtesy to be able to suggest a colleague to other patients.

XII. Insurance:

- A. Malpractice Insurance: A refund on unused premiums may be possible. Find the policy and consult the local agent.
- B. Liability and other Insurances: Certain policies issued with reference to the practice might have provisions for refund of unused premiums. Consult the issuing company or insurance agent.
- C. Blue Cross and Blue Shield: A widow of a physician who was a member of the county medical society should check as to provisions for transferring policies to individual basis.

XIII. Veterans Administration: If the Doctor was



a Veteran, notify the Veterans Administration with the indicated information and apply for deserved benefits.

Obtain Veterans Administration Fact Sheet IS 1 from the Veterans Administration. It contains a good summary.

In this connection, save the Doctor's discharge papers permanently. It is possible that Pensions or other forms of remuneration may be provided in the future.

XIV. Social Security: If there is any possibility of coverage, visit the local Social Security office with the Social Security or Taxpayer Identification number.

It should be pointed out that the doctor may have been covered by Social Security during internship. Time in the Armed Forces is counted for certain periods, and the Doctor may have had some covered part-time medical position, as well as coverage in employment prior to graduation from Medical School.

XV. Automobile(s): Title, if in Doctor's name, can be transferred with assistance of automobile club, if a member. Also be sure insurance coverage is retained.

XVI. Equipment: It is best disposed of as part of the practice, if possible. Otherwise, it might be possible to obtain an estimate of value from one of the

reputable equipment vendors and then sold either privately, through an advertisement or to a dealer on used equipment. Equipment dealers are listed in the Yellow Page Directory under Physicians and Surgeons Supplies and Equipment. The sale value of used equipment is low.

XVII. Current bills: These must be paid, but not until the court has approved the Executor or appointed the Administrator of the Doctor's estate.

XVIII. Magazine subscriptions: Those purchased for office use might be checked for possible stoppage and subscription refund if you do not wish to continue them.

XIX. Dues: There is ordinarily no refund on Medical Society dues unless hardship exists.

XX. Securities: It is worth noting that Securities can be used as collateral for loans to meet financial needs. This may be preferable to selling the securities.

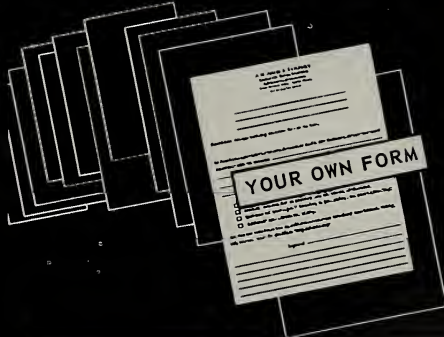
**Editor's Note:** The Cleveland Academy in a recent issue of its *Bulletin* also published a form entitled "Set Your Affairs in Order." Blank spaces are provided on which the physician can list much of the information suggested in the foregoing list. Forethought in this matter will save survivors many a headache in seeking out necessary information.

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If stock forms do not satisfy your needs, why not design your own?

Send us a pencil sketch of your design for quotation. A reasonable one-time charge covers the initial art work and composition, after which your own form will cost you practically the same as a stock form . . . and you have exactly what you want. No obligation if you think our quotation is too high (you won't).

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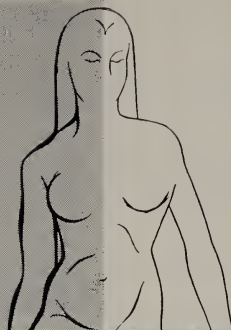
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emphatic dietary reform with  
little C. N. S.\*\* stimulation

# CYDRIL®

(Levamphetamine Succinate)



**TWO CONVENIENT DOSAGE FORMS . . .**

Each **CYDRIL** (levamphetamine succinate) Granucap\* contains:

levamphetamine succinate

21 mg.

(Releasing the drug over a 6-10 hour period)

Each **CYDRIL** (levamphetamine succinate) Tablet contains:

levamphetamine succinate

7 mg.

**Side Effects:** Rare—C.N.S.\*\* stimulation minimal, occasionally cardiovascular and gastrointestinal reaction may be observed.

**Contraindications:** Severe hypertension, angina pectoris, hyperthyroidism and Raynauds disease.

**Available:**

GRANUCAPS\*—Bottles of 100, 1000

TABLETS—Bottles of 100, 500, 1000

Request clinical samples and literature on your letterhead.

\*Granucaps—T.M. Reg. U.S. Pat. Off.

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If you have moved, you will want *The Journal* and other OSMA mail sent to your new address. Please complete the coupon and mail it to us immediately since it takes several weeks to have new stencils made for the mailing list.

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### Notice of Change of Address

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Street

City

Zip code

TELEPHONE .....

SEND MAIL TO ☐ Office address ☐ Home address



# in maintenance therapy... a working analgesic for the active arthritic

## ARTHRALGEN®

Each tablet contains:

Salicylamide.....	250 mg.
Acetaminophen.....	250 mg.
Ascorbic acid (Vitamin C).....	25 mg.

### a working analgesic for the active arthritic

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

### two proven pain relievers

Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

### sodium-free

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.<sup>1</sup>

## ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

Salicylamide.....	250 mg.
Acetaminophen.....	250 mg.
Ascorbic acid (Vitamin C).....	25 mg.
Prednisone.....	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.<sup>2</sup>

### BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

**DOSAGE:** One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

**SIDE EFFECTS:** Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticism dictate reduction of dosage of Arthralgen-PR.

**PRECAUTION:** Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

**CONTRAINDICATIONS:** Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

**SUPPLY:** Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

**REF:** 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.  
2. Cohen, et al.: J.A.M.A., 165:225, 1957.

A. H. ROBINS COMPANY, INCORPORATED/RICHMOND, VIRGINIA

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220

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# AMYCIN<sup>®</sup>

## OXYTETRACYCLINE

**Contraindicated:** In patients hypersensitive to oxytetracycline.

**Warning:** Reduce usual dosage and consider antibiotic serum level determinations in patients with impaired renal function. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

**Precautions:** Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood

vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.

**Adverse Reactions:** Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

**Supply:**\* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc. Terramycin (oxytetracycline) Intramuscular Solution: available as ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject<sup>®</sup> syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

\*All potencies listed are in terms of the standard, oxytetracycline.

*More detailed professional information available on request.*

## American People Well Protected Through Health Insurance

By the end of 1964, an estimated 149 million Americans were protected by some form of health insurance against the costs of ill health, the Health Insurance Institute reported in a review of the past year.

This figure represents 78 per cent of the U. S. civilian population, the Institute said, and is an increase of 3.7 million persons over the number protected in 1963.

Benefits paid to insured persons last year were estimated at \$8.6 billion or some \$800 million more than in 1963. These benefits were paid by over 1,800 insuring organizations including 903 insurance companies, 77 Blue Cross and 72 Blue Shield plans, and nearly 800 other health care plans.

The Institute said that record highs were established in 1964 in both the number of persons protected and in the amount of benefits paid out.

Of the 149 million persons protected under hospital insurance in 1964, an estimated 139 million persons also had surgical expense insurance and 105 million also had regular medical coverage. The increases over the 1963 totals for surgical and regular medical insurance were 4.1 million and 3.3 million persons respectively.

Major medical expense insurance, provided by insurance companies, continued to be the fastest growing of all health insurance programs, the Institute said. In 1964, an estimated 45.5 million persons had major medical insurance protecting them against the costs of serious illness or injury, either in or out of the hospital. That's an increase of 8.3 per cent or 3.5 million persons over the number protected under major medical in 1963.

Loss-of-income insurance which helps to replace lost wages of insured persons when they are disabled due to illness or injury, protected an estimated 48 million persons in 1964, the Institute said. This is an increase of one million persons over the number protected in 1963.

Benefits paid to persons insured by loss-of-income policies totaled an estimated \$997 million in 1964. In 1963, \$936 million were paid out. (These figures exclude accidental death and dismemberment benefit payments.)

### Cleveland Anesthesiologists Announce 1965 Officers

The Cleveland Society of Anesthesiologists announced the following officers for 1965: Dr. Steven Kovacs, president; Dr. Donald E. Hale, vice-president; Dr. John P. Debly, treasurer; Dr. Melvin A. Lucas, secretary (the second year of a two-year term); Dr. Carl Wasmuth, Board of Directors (second year of two-year term); and Dr. Anna P. Dumitru, Board of Directors.

## Hygroton®

brand of  
chlorthalidone

## the long-acting diuretic

### Indications

Many types of edema involving retention of salt and water.

### Contraindications

Hypersensitivity, and most cases of severe renal or hepatic disease.

### Precautions

Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

### Side Effects

Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

### Average Dosage

One tablet (100 mg.) daily with breakfast.

### Availability

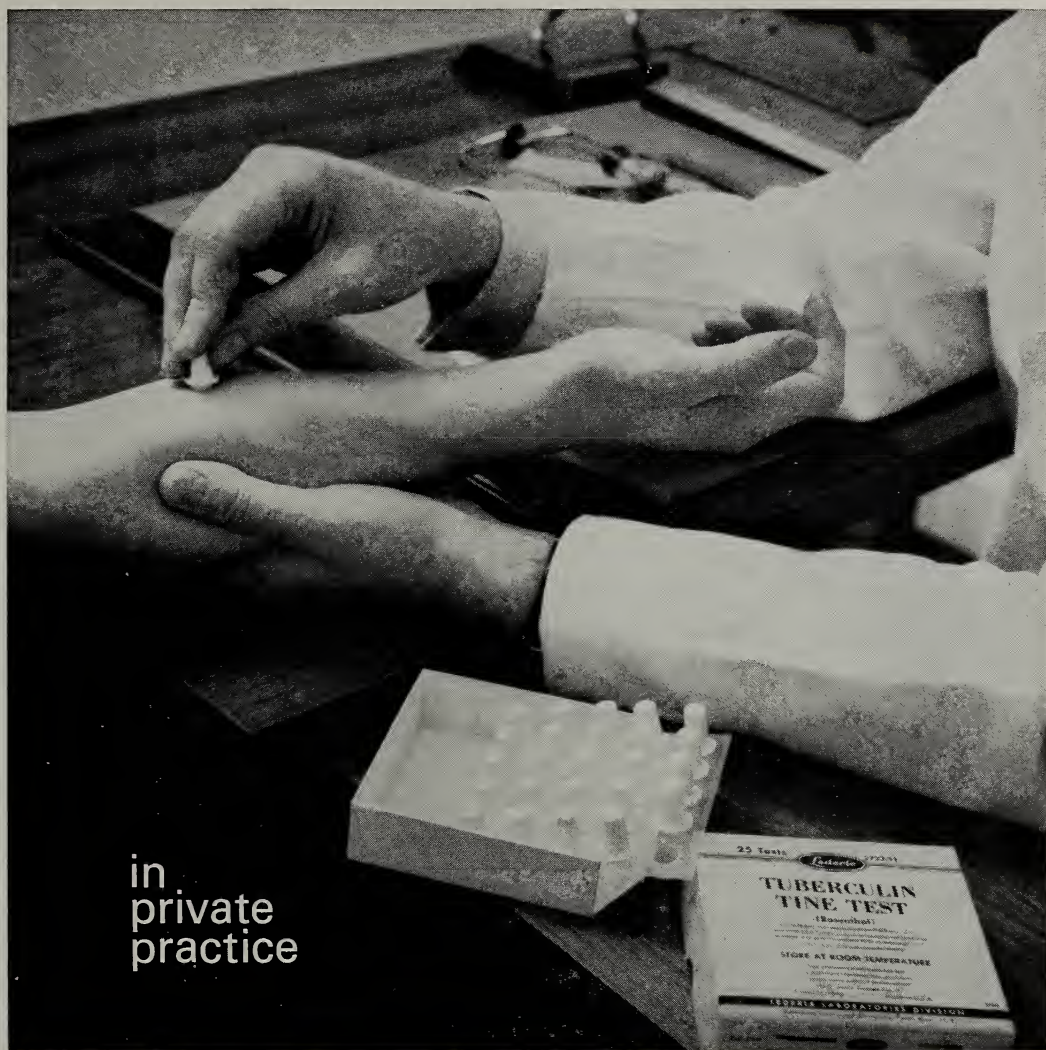
Tablets of 100 mg. in bottles of 100 and 1000.

For full details, see the complete prescribing information.



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Division of  
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# TUBERCULIN, TINE TEST

(Rosenthal) Lederle

**ideally suited for routine TB screening**

**accurate**—comparable to the older standard intradermal tests

**practical**—can be administered by nurses or other personnel

**convenient**—no refrigeration or other storage precautions

**economical**—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. Available as the new individually-capped unit, boxes of 5, or in cartons of 25.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

9635-5



# A Century of Sanitary Fairs and Health Expositions in Ohio

1864 - 1964

BRUNO GEBHARD, M.D.\*

## PART V

(Concluded from January Issue)

### Cincinnati Health Exposition — 1921

CINCINNATI took the lead again with a Health Exposition in 1921. The word "Sanitation" had been out of circulation more or less since the turn of the century, except in relation to sewage disposal or as "sanitary engineer." Preventive Medicine, Periodic Health Examination, Health Propaganda and Publicity had replaced Bowditch's clarion call for State Preventive Medicine.

The 1921 Cincinnati Health Exposition was under the motto "Live A Little Longer." Its promoter was the newly created (1919) Cincinnati Public Health Federation with Bleecker Marquette and Julian E. Benjamin, M.D., as the moving spirits. The proposal of the exhibition was threefold:

- To show how to prevent needless death, needless illness, and needless suffering;
- To demonstrate the advances of medical sciences;
- To visualize how public health efforts are safeguarding the public health.<sup>19</sup>

Two hundred thousand people visited the Exposition from October 15 to 21. Children were admitted free when coming in school groups or accompanied by an adult who paid a 25 cent admission charge. The Exposition reported an investment of \$30,000, but had a surplus of \$2500, which was turned over to the Community Chest.

There were both educational and commercial exhibits, mainly from pharmaceutical houses, totalling 200 units. The auditorium program showed a Health Pageant, "Best Babies Contests," and "Best Teeth Contests." The basic idea was "to educate the visitors

in a painless way without the intolerable toil of thought."<sup>20</sup> The content of the exhibits reflected major health problems of those days: bad sanitary conditions in tenement houses; a large mechanical fly blinking every 10 seconds to indicate the mortality among children caused by diseases spread by flies; one hospital proudly showed \$250,000 worth of radium for cancer treatment; the Academy of Medicine propagated the principle of clean milk through better dairy inspection.

### Cincinnati's Centennial Exposition — 1957

The famous Music Hall was again the place for a Centennial Exposition in Cincinnati in 1957, from February 27 to March 5, in commemoration of the 100th anniversary of the Academy of Medicine of Cincinnati. Howard D. Fabing, M.D., President of the Academy, was the moving spirit. The March 1957 issue of *The Cincinnati Journal of Medicine* was dedicated as the Centennial issue.

The legal sponsor was the "Cincinnati Health Museum and Exposition Inc." (1955). Besides its main objective "to promote general health in this community" others were stated as "to attract more persons into employment in the fields of Medicine, Health Research, and Science" and also "to provide an excellent public relations medium for the participating exhibitors." Compared with the 1921 Exposition, new fields showed up in the 1957 Roster of Exhibits, e. g.: a dozen medical specialty groups, an exhibit "Atoms for Peace," and Blue Shield and Blue Cross. The total number of exhibits was 175, including a copy of the transparent woman "Juno," the original being at the Cleveland Health Museum.

Radio talks dramatized the 100-year history under the title "Cincinnati Doctor." Nationally known

(Continued on Page 126)

<sup>19</sup>Read at the 1964 Annual Meeting of the Ohio Academy of Medical History, April 18, 1964, Granville, Ohio.

\*Dr. Gebhard, Cleveland, is Director of the Cleveland Health Museum, 8911 Euclid Avenue, Cleveland, Ohio.



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speakers could be heard, and a motion picture theater showed the latest in health and medicine.

### A Health Fair in Columbus

Except for the Ohio State Fair, Columbus had nothing to show in the line of health fair educational activities until 1959. From March 25 to 29, such a fair drew 110,000 visitors to the Veterans Memorial Building. The Columbus Academy of Medicine was the sponsor. Its 850 members assessed themselves \$15 per capita to make the Health Fair a strictly noncommercial venture. Earl H. Baxter, M.D., the Chairman of the Board, and "Bill" Webb, the Executive Secretary, were the driving forces besides many physicians who served not only as committee members, but also as demonstrators at the exhibits. A unique feature provided for the Columbus Hospital Federation was a hospital corridor showing 14 fully equipped hospital rooms.

The public response to the Health Fair was so great—thousands had to be turned away on the afternoon of the last Fair Day—that the Academy decided to look for a permanent home of health exhibits. This was realized five years later as a part of the Center of Science and Industry, a nonprofit organization, "dedicated to the advancement of knowledge in the fields of Science, Industry, Health and History," which, on March 28, 1964, opened its doors to the public. The Center is sponsored by the Franklin County Historical Society. The old War Memorial Building on East Broad Street has

been completely modernized and now has on its first floor what amounts to the second Health Museum in Ohio. Besides the Academy of Medicine, the Columbus Dental Society, the Central Ohio Heart Association, and the Columbus and Franklin County Tuberculosis Society are sponsors of many health exhibits which originated at the Cleveland Health Museum.\*

Historical Societies have up to now paid little attention to the development of health and medicine, but one of the first in Ohio, not only to concern itself with the past, is the Stark County Historical Society. It opened in a new building in the summer of 1963, a Hall of Science and Industry, which includes a Health Education Center, another name for a one-room Health Museum. It contains exhibits on the Miracle of Birth, on Nutrition, and, as a special feature, the Vesalius Lady, a new addition of a transparent talking woman.

Health Expositions and Health Fairs are not limited to Ohio. They are springing up all over the nation and have been the pacemakers for permanent Health Museums, of which the first one was incorporated in Cleveland in 1936 and opened to the public in 1940.

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\*For the origin and the first decade of the Cleveland Health Museum, see Bruno Gebhard "From Cincinnati's Western Museum to Cleveland Health Museum" Ohio State Arch. and Historical Quarterly, Vol. 59/4/371-384, Oct. 1950.

**N**ATIONAL LIBRARY OF MEDICINE.—One hundred and twenty-five years ago Dr. Joseph Lovell, Surgeon General of the U.S. Army, authorized a budget item which called for "150 medical books" and began a collection which is today the National Library of Medicine. The library opened to the public in 1888, eight years after the introduction of the Library's *Index-Catalogue*, internationally famed author-subject references, and the *Index Medicus*, a monthly bibliographic key to current medical literature.

A twenty-five minute, color film which shows current operations of the medical library in providing medical information from all over the world to the health professions of the United States, has been produced and released for distribution by the U.S. Public Health Service Audiovisual Facility. Methods of cataloging and indexing are described to show how the library collection of more than one million books, serials, and pamphlets is made available to library users. Shown also are rare volumes published before 1801 held in the History of Medicine Collection and modern, high-speed equipment which indexes 150,000 current references annually. Reference services of the library, international acquisition program, and library loan policies are described. Designed for members of the health professions and medical librarians, the film is also of interest to lay audiences.

Prints of the film, listed as NATIONAL LIBRARY OF MEDICINE (M-523) Motion Picture — 16mm — color — sound — 25 minutes — 1963, are available on free loan from Chief, Distribution Unit, Public Health Service Audiovisual Facility, Communicable Disease Center, Atlanta, Georgia 30333.





# Scientific Section

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## Polypoid Lesions of the Colon And Rectum

### A Discussion of Recognition and Management

CHARLES H. HAMILTON, M.D., WALTER W. HAMILTON, M.D., and WALTER H. HAMILTON, M.D.

GROSSLY polypoid neoplastic lesions occur with significant frequency in the colon and rectum. These anatomical areas are readily accessible for both diagnostic examination and therapeutic procedures. It is important that the clinician be able not only to recognize the physical presence of these colorectal neoplasms but also to determine their pathologic significance in order to achieve the optimum therapeutic result.

Prior to 1958, the standard surgical attitude was to regard all adenomas of the colon and rectum as precancerous tumors. Then a provocative paper<sup>1</sup> appeared, which has stimulated much controversy in surgical circles and has served to force reassessment of our surgical philosophy with regard to management of these lesions. Other valuable articles<sup>2,3</sup> have been published, which clarify the oftentimes confusing terminology and which more accurately classify and describe the pathologic behavior of colorectal new growths. It is our purpose, in this paper, to indicate in the light of investigation and experience emerging from the last five years, what we believe is a sound approach to diagnosis and effective management of patients who harbor rectal and colonic neoplasms.

#### Classification and Terminology

Much confusion exists with regard to classification and nomenclature used to describe polypoid lesions of the bowel. There is no universal set of standards

#### *The Authors*

● Dr. C. H. Hamilton, Columbus, is a member of the Attending Staff, Surgery, Riverside Methodist Hospital; Associate Staff, Surgery, St. Anthony Hospital; Clinical Instructor in Surgery, The Ohio State University College of Medicine.

● Dr. W. W. Hamilton, Columbus, is Senior Resident, General Surgery, Riverside Methodist Hospital.

● Dr. W. H. Hamilton, Columbus, is a member of the Senior Attending Staff, Surgery, Riverside Methodist Hospital; Attending Staff, St. Anthony Hospital; Assistant Professor of Surgery, The Ohio State University College of Medicine.

for pathologists to follow, thus leading to disagreement and misinterpretation, which often confounds the surgeon and limits the effectiveness of his patient management.

Morson<sup>2</sup> has suggested a classification of polypoid lesions of the colon and rectum which seems tenable. He categorizes the epithelial adenomatous growths separately from the hamartomatous lesions. The former are precancerous and the latter, of which juvenile polyps and the polyps of Peutz-Jeghers syndrome are examples, are definitely not.

In a remarkably lucid paper, Castleman<sup>3</sup> emphasizes

the need to differentiate three major groups of polypoid lesions for the purpose of more intelligent and appropriate treatment. Otherwise, undertreatment or overtreatment may inadvertently occur, to the ultimate disadvantage of the patient. The first group is the adenoma (or adenomatous polyp); the second is the papillary (or villous) adenoma; and the third is the polypoid carcinoma. Each has its own clinical significance based on pathologic behavior of the lesion.

### Clinical Significance of Pathologic Findings

The adenomatous polyp is formed by focal hyperplasia of mucosal glands. This generally results in a compact soft mass with a fibrovascular stalk or pedicle. Most often pedunculated adenomas will average 1 to 1.5 cm. in diameter, although larger size may be attained. Grinnell<sup>4</sup> and Spratt<sup>5</sup> have both emphasized that such lesions over 1.5 cm. in size have a considerably greater chance of containing carcinoma (9 to 12 per cent) than those of smaller diameter (1 per cent). The presence of a stalk or pedicle seems to be an optimistic finding since reported metastases from pedunculated, cancer-containing adenomas are extremely rare.

Papillary adenomas are broad based, flat tumors with many small surface villous projections. The primary microscopic features are multiple papillary projections springing over a wide surface directly from the basement membrane. Grossly these lesions are soft, velvety, and secrete large amounts of mucus. Occasionally, electrolyte disturbances, especially potassium deficit, will occur due to excessive mucus secretion. These tumors usually attain much larger size than the adenomatous polyps and generally average 3 to 4 cm. in diameter. They have a particular predilection to occur in the rectum and rectosigmoid segment of the bowel and may entirely encircle the lumen.

Although the papillary adenoma is considered by most authorities to be a growth variant of the adenomatous polyp, there is rather uniform agreement that the papillary adenoma is a much more treacherous lesion and must be regarded as having a greater malignant potential. Grinnell<sup>4</sup> reported a comparative incidence of carcinoma in adenomatous polyps of 2.9 per cent contrasted with 31.9 per cent in papillary adenomas. Enterline<sup>6</sup> studied 1700 polypoid lesions removed from the colon and rectum. He observed that 45 of 81 cases (55 per cent) of the papillary adenomas contained invasive carcinoma. One third of these lesions caused metastases to the regional lymph nodes and caused the death of the patient in 22 per cent. In contrast, an approximately similar number of adenomatous polyps containing carcinoma showed no regional node metastasis and resulted in no mortality.

The polypoid carcinoma occurs much more infrequently than either of the other lesions. It is char-

acterized by the complete absence of any benign adenomatous tissue on microscopic section. Its major importance lies in the fact that it is grossly polypoid and may be mistaken for an adenomatous polyp. Comments regarding treatment will appear later in this paper.

Polypoid lesions generally keep bad company, and the clinician must be constantly on the alert for other co-existing disease. Helwig<sup>7</sup> found a 20 per cent incidence of adenomatous polyps in specimens of colon resected for carcinoma. Bacon and Broad<sup>8</sup> reported 31 per cent concomitant adenomas in 173 colon resections for carcinoma. Bacon and Peale<sup>9</sup> noted multiplicity of adenomatous polyps in 33 per cent of 200 patients.

Jackman and Hill<sup>10</sup> have described other polypoid lesions of the large intestine which may occur and be confused with true polypoid tumors of epithelial origin. These lesions have certain distinguishing characteristics and can be diagnosed satisfactorily by adequate history, physical examination, and radiographic study. Occasionally biopsy and histologic examination are necessary to confirm the clinical impression.

The presence of hard, gritty or nodular areas in an otherwise soft tumor is suspicious of malignancy. Ulceration occurring within a polypoid lesion must be regarded as cancer until proved otherwise by biopsy.

### Diagnostic Methods

A pertinent historical review of symptoms should always precede physical examination of the patient. Rectal bleeding, passage of excessive mucus, abdominal cramping, and tenesmus are always significant symptoms. However, many patients may have a paucity of complaints and perhaps none at all. It nevertheless remains for the clinician to maintain a high index of suspicion and to follow through with a systematic diagnostic plan.

Digital-rectal examination will yield some positive findings in possibly a third of the cases, although, admittedly, soft polypoid lesions are more difficult to palpate than a characteristically hard or gristly carcinoma. The presence of blood or blood stained mucus on the examining finger should lead methodically to endoscopic visualization of the mucosal lining.

Sigmoidoscopic examination with the 25-centimeter instrument will markedly increase the diagnostic yield, for approximately three fourths of the pathologic neoplastic processes occurring in the colon and rectum can be visualized in this way.

Barium enema examination of the colon by x-ray provides a helpful supplement to the physical examination. However, where polypoid lesions are concerned, the diagnostic accuracy of colon x-ray has definite limitations. In spite of capable radiologists and consistently satisfactory cleansing of the colon, lesions 1 centimeter and less in size may be over-



looked in as many as 50 per cent of the cases.<sup>11-12</sup> Even polypoid growths of considerable size may be missed when they occur in "problem loci" of the colon, for example the cecum. The double air contrast technique may significantly increase the recognition of smaller lesions but only if preparation of the bowel is meticulous. Both Ferguson<sup>11</sup> and Deddish<sup>12</sup> have strongly recommended the use of operative colonoscopy to augment the diagnostic accuracy of standard radiographic examination using barium, where the procedure is otherwise indicated.

A polypoid lesion of the colon above sigmoidoscopy distance must always be demonstrated on at least two barium x-ray examinations before laparotomy is scheduled. More than one eager surgeon has been embarrassed to find that the polyp had "disappeared" when it appeared to be all too obvious on the single x-ray examination that was performed.

### Treatment

To be most effective, yet safe for the patient, therapy must be guided by several factors. The size, consistency, appearance, location, and histologic type of the neoplasm are all considered. However, the clinical experience of the surgeon, as emphasized by Turnbull,<sup>13</sup> is of primary importance and must be the ultimate determining factor in how the case is managed. He should consult freely with the pathologist and strive to develop and maintain a clear understanding with him as these lesions are evaluated and treated. However, the pathologist should not be placed in the uncomfortable position of having to make major decisions regarding treatment. This should lie exclusively in the domain of the clinician and surgeon who relates all the findings and makes his judgment accordingly.

Ideally, total excision and thorough histologic examination of every polypoid lesion should be performed. Sometimes, however, this may be impractical and even hazardous.

Physical characteristics and gross appearance are helpful in determining the pathologic nature of the growth, and therefore, the treatment. The presence of ulceration or existence of hard, nodular or gritty areas are highly suspicious of frank malignancy. Such findings should motivate wider, more radical excision. Soft, mobile, non-ulcerated lesions are much less likely to contain malignant cells and can therefore be adequately treated by local excision, if this is surgically feasible. Neoplasms greater than 1.5 cm. in diameter stand a significantly greater chance of being malignant than those of smaller dimensions. Pedunculated lesions are safer than sessile ones and can be locally removed with greater security.

The location of the growth may influence the mode of surgical management considerably. Certain lesions in the rectum or near the anal sphincters demand extra circumspection for these tumors may require sacrifice of the rectum as the best treatment. Adequate thought and consideration must be given prior to

radical therapy of this sort. Growths which arise higher in the rectum or colon often lend themselves more readily to surgical excision even though laparotomy may be required.

The histologic findings are valuable diagnostic adjuncts and help the surgeon decide on the best course of treatment. However, certain shortcomings exist which can confuse the picture and may lead to mismanagement. For example, multiple biopsies from a large papillary adenoma may all be reported benign, and yet a focus of invasive carcinoma may be missed. A false sense of security thus may lead to inadequate treatment. Castleman<sup>3</sup> has pointed out how a frozen section diagnosis, at the time of operation, may be misleading to the surgeon and therefore result in overradical treatment. Permanent sections may later reveal simply a benign adenoma or foci of histologic cancer without evidence of invasive malignancy. In such a situation, local excision would be perfectly adequate treatment, and a radical resection with its attendant greater morbidity and mortality could be avoided.

In general, the adenomatous polyp, even those with foci of histologic cancer, can be safely treated with local excision. Both Turnbull<sup>14</sup> and Swinton<sup>15</sup> have reported satisfactory long-term results in patients treated with local excision for polypoid lesions, even when there is evidence of invasive carcinoma. However, when there is invasion of the pedicle by the malignant process, radical excision is necessary. Benign adenomas may be removed from the rectum by biopsy and fulguration, by cautery snare removal through the sigmoidoscope, or, if low enough, by transanal ligation and excision. Lesions beyond the reach of the sigmoidoscope require laparotomy, colectomy, and local excision. Total colonoscopy should be used where there is no obvious contraindication, since the yield of extra lesions, not visible by normal radiographic techniques, may approach 50 per cent.

As both Ferguson<sup>11</sup> and Deddish<sup>12</sup> have emphasized, meticulous preoperative preparation is mandatory for successful operative colonoscopy. If the lesions are too numerous to make multiple local excisions feasible, segmental resection or even subtotal colectomy may be necessary. Sessile lesions are more safely treated by resection, the extent of which should be determined by the gross findings and perhaps with the help of frozen sections.

The papillary adenoma is a more challenging lesion to treat, both for anatomic and pathologic reasons. Its malignant potential is much greater than the adenomatous polyp, and radical treatment is not only more often necessary but is also justified. The papillary adenoma is most often sessile and tends to occur in the rectal segment. When the lesion attains large size, it may be inaccessible, and total excision, with the expectation of satisfactory rectal function, may be impossible. For smaller sized papillary adenomas, without biopsy or clinical evidence of malignancy,

transrectal excision and thorough fulguration should be performed. For larger or less accessible lesions, or in cases where more radical excision is contraindicated, posterior proctotomy with or without anal sphincter division can be utilized. This method gives better control and exposure and yet avoids certain physiologic stresses inherent in laparotomy and other more radical procedures.

Any papillary adenoma with biopsy evidence of malignancy or large lesions which encompass the lumen or are otherwise inaccessible for total removal should be treated with combined abdomino-perineal resection of the rectum. Similar lesions at a higher level in the rectum or sigmoid colon should be resected with a generous portion of the mesentery and node bearing tissue followed by a primary anastomosis.

The rare polypoid carcinoma, which may occur and grossly mimic an adenomatous polyp, should be treated with radical excision. If the lesion is well pedunculated or if there is medical contraindication to radical surgery, such a growth may be locally excised with the knowledge that there is less likelihood of recurrence or metastasis than in a frank, ulcerating, infiltrating carcinoma.

The follow-up care for patients who have been treated for polypoid disease of the colon and rectum is of utmost importance. The routine management is rather well standardized for most patients. Sigmoidoscopic examination should be performed every six months for the first two or three years, then annually for the next two years. A barium enema examination should be carried out annually for three years then as often as symptomatology or endoscopic findings seem to dictate. Flexibility should always be maintained and the judgment of the physician should determine the follow-up schedule rather than adhering strictly to any set of rigid dicta.

### Case Illustrations

**Case 1:** A 43 year old white man presented with a six week history of painless rectal bleeding. No associated abdominal symptoms were present. Sigmoidoscopic examination was clear to the 25-centimeter level, except for bloody mucoid discharge apparently coming from above. Barium enema revealed a large polypoid tumor of the descending colon. A repeat examination confirmed the presence of the lesion.

Laparotomy, multiple colotomies, and subtotal colonoscopy were carried out. The entire left and transverse colon segments were inspected. The right colon was left undisturbed due to extensive adhesions in the ileocecal region. Wedge excision of a pedunculated adenoma of the descending colon was performed. Postoperative convalescence was uncomplicated. Surgical tissue report indicated *an adenomatous polyp with focal atypia*.

**Case2:** A 62 year old white man was found to have a polypoid lesion by barium enema done routinely prior to anorectal surgery. Sigmoidoscopic examination was clear to the 25-centimeter level.

The past medical history showed chronic pulmonary disease with emphysema. The patient had significantly diminished timed vital capacity and dyspnea on exertion.

After adequate medical evaluation and preoperative preparation, including confirmatory barium enema, the patient was submitted to trans-abdominal colotomy, wedge excision of a pedunculated adenoma of the sigmoid colon, and colonoscopy limited to the left colon. More extensive colon-

oscopy was not carried out due to the reluctance to extend anesthesia and operative time. The patient recovered without complication or infection. Surgical tissue report indicated *benign adenomatous polyp of the colon*.

**Case 3:** A 50 year old white man had a chief complaint of severe rectal bleeding and protrusion for six months. With each defecation, the patient prolapsed a fleshy polypoid mass from the anal orifice. There was copious leakage of mucus and bloody discharge. Sigmoidoscopic examination revealed a large, soft, mobile mass in the rectal ampulla. No other lesion was seen to the 20-centimeter level. On digital-rectal examination, a soft mass could be palpated as the patient strained down. Utilizing the toilet test, the patient could prolapse the mass from the anal orifice without difficulty. Barium enema examination of the colon revealed no other defect or polypoid lesion.

Under general anesthesia, the patient was subjected to trans-rectal ligation and excision of the prolapsed polypoid mass. The tumor was attached to the mucosa by a rather long, linear pedicle. Postoperative convalescence was uneventful. Surgical tissue report indicated a *benign adenomatous polyp of the rectum*.

**Case 4:** A 54 year old white man was entirely asymptomatic. During a routine physical examination, a polypoid lesion of the rectosigmoid was discovered on barium enema. No other lesions were visualized in the remainder of the colon. Sigmoidoscopic examination demonstrated a pedunculated tumor at the 15-centimeter level. No other neoplastic or inflammatory lesion was seen.

The patient was subjected to trans-rectal, cautery snare excision of the pedunculated lesion through the sigmoidoscope. No technical difficulties were encountered. The patient made an uncomplicated recovery. Surgical tissue report indicated an *adenomatous polyp of the colon*.

**Case 5:** An 84 year old white man presented with the chief complaint of left lower quadrant pain, chills, and fever of several days' duration. There was a past history of diverticulitis of the colon. There had been no rectal bleeding, but the patient would intermittently pass clear mucus.

Abdominal examination revealed moderate tenderness in the left lower quadrant. Sigmoidoscopic examination showed a large polypoid lesion of the rectum at the 10-centimeter level. A barium enema examination reported diverticulosis with segmental diverticulitis of the sigmoid. The polypoid tumor of the rectum was also demonstrated.

The patient was subjected to posterior proctotomy and coccygectomy without anal sphincter division. Full thickness excision of the polypoid growth of the rectum was performed and a two-layer repair of both the excision site on the anterior wall and ampullary incision on the posterior wall were accomplished. Drainage of the presacral and pararectal spaces was established. The patient made a slow but uncomplicated recovery. He was discharged improved. Surgical tissue report indicated *adenomatous polyp of the rectum, benign*.

### Summary and Conclusions

1. An attempt is made to elucidate the differences in polypoid lesions of the colon and rectum.
2. A plea is made for a clearer conception of classification and terminology to promote better understanding among those who encounter these lesions and thus more effective treatment.
3. The clinical significance of pathologic findings is presented, emphasizing the comparatively greater importance of the papillary adenoma as a more challenging and potentially more lethal neoplasm than the adenomatous polyp.
4. Diagnostic methods are enumerated, pointing out certain shortcomings and weaknesses which may lead to less effective management.
5. Modes of therapy are suggested for the various lesions which may occur, and case illustrations are



presented. The need for closer cooperation and understanding between surgeon and pathologist is emphasized.

6. Follow-up recommendations are made and the importance of this component of the overall management is stressed.

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**HISTOPATHOLOGY OF STEROID-INDUCED ULCERS.**—Prednisolone, 0.5 to 10.0 mg., administered subcutaneously to rats fasted for four days, produced multiple ulcers in the glandular portion of the stomach. One hour before sacrifice, ferric chloride (30 mg.) was given orally, and at autopsy, the opened stomach was submerged into acidified potassium ferrocyanide. An intense blue color (Prussian blue) developed instantaneously at the sites of ulcers, leaving intact areas unstained. Each ulcer was surrounded by a thin halo line of Prussian blue. The number of ulcers per stomach was found to be proportional to the dose of steroid. This method can be used as an assay for the ulcerogenicity of steroids.

Histologically, the following changes were observed: (1) Steroid ulcers involved half or more of the mucosa, sometimes penetrating the muscularis mucosae. There was no fibrosis. (2) Prednisolone markedly reduced the amount of mucus (PAS technique) in the corpus but only slightly in the antrum. Ulcers were limited to the corpus and never appeared in the antrum. On the sides of ulcers there was always a group of glands containing newly formed mucus, both intracellular and free into the lumina. (3) In some cases, the crater was covered with a proliferating unicellular membrane, originating from the adjacent mucus epithelium. (4) Prussian blue was found impregnating (a) the necrotic mass of the crater, sharply demarcating necrotic from living tissue; (b) the mucus of the antrum but not of the corpus; and (c) the mucus of the glands surrounding an ulcer.

These findings support a theory of ulcerogenesis based on the protective role of mucus. Such a protective function can be surmised from the following facts: The antrum is rich in mucus and does not ulcerate.

Mucus content of the corpus is rapidly reduced by steroids, and this reduction coincides with ulcer formation.

Newly formed mucus is secreted in the immediate vicinity of an ulcer by mucus cells rapidly proliferating. This may represent a local defense reaction tending to protect the tissue from further erosion and to favor healing.

Iron is trapped by antrum and periulcer mucus, but not by corpus mucus, suggesting structural differences of mucus depending on its location. Mucus in antrum and around ulcers would appear to have greater protective property than corpus mucus.

Finally, mitoses in gastric mucosa are found exclusively in mucus cells (surface epithelium and mucus neck cells). This indirectly suggests that mucus cells are specialized in repair and regeneration, a process necessary for healing of ulcers. Andre Robert, M. D., and James E. Nezamis, M. D., *Archives of Pathology*, 77:407-423 (April) 1964.

# Smoking Habits and Disease in Ohio\*

E. CUYLER HAMMOND, Sc.D., and LEO F. GERBER, M.Ed.

A HIGH DEGREE of relationship between cigarette smoking and death rates of men has been found in six previous prospective studies carried out in this country, Great Britain, and Canada.<sup>1-6</sup> In this paper, we will present findings on this subject in the first 34.4 months of follow-up in the Ohio segment of a large prospective epidemiological study which was started in 1959 and is still in progress.<sup>7-10</sup>

During the latter part of 1959 and early 1960, volunteer workers of the Ohio Division of the American Cancer Society enrolled 88,527 men and women, the mean date of enrollment being November 18, 1959. The study area encompasses 81 of the 88 counties of Ohio. Upon enrollment, each subject answered a detailed questionnaire covering many factors including past and present smoking habits. The subjects are traced once a year and are requested to fill out brief questionnaires once every two years. In the most recent completed follow-up, 99.5 per cent of the subjects were traced through September 30, 1962. (The next follow-up was started on October 1, 1963 and is still in progress.) When a death is reported, we request the Ohio Health Department to supply us with a copy of the death certificate; and when cancer is mentioned on a death certificate we request the doctor to supply additional information.

This report is confined to the records of 35,063 men between the ages of 40 and 89 who were traced through September 30, 1962. Of these 35,063 men, 1,478 (4.2 per cent) were reported to have died; and we now have copies of the death certificate on 1,472 of them. Cancer was mentioned on 273 of the certificates and doctors have provided additional information on 88 per cent of them.

## Physical Complaints

A list of various physical complaints was printed on the first questionnaire and the subject was asked to check "yes" or "no" after each of them to indicate whether or not he had the complaint "at present." Those who had a complaint were asked whether it was "slight," "moderate" or "severe." Of the 35,063 men between the ages of 40 and 89, 10,978 said that they were currently smoking 20 or more cigarettes

## The Authors

● Dr. Hammond, New York, New York, is Director, Statistical Research Section, Medical Affairs Department, American Cancer Society, Inc.; Lecturer in Preventive and Environmental Medicine, Albert Einstein College of Medicine.

● Mr. Gerber, Cleveland, is Executive Vice-President, Ohio Division, Inc., American Cancer Society.

a day and 7,403 said that they had never smoked regularly. Table 1 shows the number and per cent of these smokers who reported having various complaints and the per cent of nonsmokers who reported having the complaints. The percentages for the nonsmokers have been adjusted to the age distribution of the cigarette smokers (this being necessary for comparability since the nonsmokers tended to be older than the cigarette smokers).

Cough, shortness of breath and pain or discomfort in chest were all reported far more frequently by the cigarette smokers than by the nonsmokers, the ratio being 3.48 to 1 for cough, 2.28 to 1 for shortness of breath and 1.58 to 1 for pain or discomfort in chest. Considering only subjects who reported these complaints to a moderate or severe degree, the ratios were 5.11 to 1 for cough, 2.86 to 1 for shortness of breath and 2.05 to 1 for pain or discomfort in chest. These findings are consistent with findings in histologic studies of changes in lung tissue in relation to cigarette smoking.<sup>11-12</sup> Such studies have shown a high degree of association between cigarette smoking and: (1) hyperplasia and the occurrence of cells with atypical nuclei in bronchial epithelium; (2) hyperactive glands in the walls of bronchial tubes; and (3) changes in the lung parenchyma including rupturing of alveolar septums, fibrosis and thickening of the walls of arterioles and small arteries.

Loss of appetite was reported over three times as frequently by cigarette smokers as by nonsmokers.

A number of other physical complaints such as hoarseness, nausea or vomiting, indigestion, pain in stomach, and a tendency to "fatigue easily" were also reported somewhat more frequently by cigarette smokers than by nonsmokers. The picture in

\*From the Ohio Division of the American Cancer Society and the Statistical Research Section of the Medical Affairs Department of the American Cancer Society, Inc.

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TABLE 1. *Physical complaints reported by 10,978 men who smoked 20 or more cigarettes per day and by 7,403 men who never smoked regularly.*

Physical Complaint	Cigarette smokers with complaint		Nonsmokers with complaint	Ratio (b) ÷ (c)
	No. of Men (a)	% (b)	% (c)	
Cough (slight, moderate, severe) .....	6,373	58.1	16.7	3.48
Cough (moderate or severe) .....	2,975	27.1	5.3	5.11
Shortness of breath (slight, moderate or severe) .....	3,860	35.2	15.4	2.28
Shortness of breath (moderate or severe) .....	1,415	12.9	4.5	2.86
Pain or discomfort in chest (slight, moderate or severe) .....	1,992	18.1	11.5	1.58
Pain or discomfort in chest (moderate or severe) .....	669	6.1	3.0	2.05
Loss of appetite .....	823	7.5	2.1	3.11
Loss of weight .....	860	7.8	6.6	1.19
Gain of Weight .....	518	4.7	4.1	1.16
Hoarseness .....	1,448	13.2	10.0	1.32
Nausea or vomiting .....	702	6.4	4.3	1.48
Indigestion .....	2,911	26.5	20.9	1.27
Pain in stomach .....	1,645	15.0	11.2	1.34
Diarrhea .....	722	6.6	5.5	1.20
Fatigue easily .....	4,286	39.0	26.4	1.48

general indicates that cigarette smokers, as a group, tend to feel less physically fit than do nonsmokers.

### Mortality

Table 2 shows the men classified by type of smoking (lifetime history). The figures under the heading "observed" are the actual number of deaths reported from the start of the study through September 30, 1962. Figures under the heading "expected" are the number of deaths which would have occurred if the age-specific death rates in each group had been the same as the age-specific death rates of men who never smoked regularly. In other words, the age-specific death rate of the nonsmokers is taken as a standard for comparison. The mortality ratio is the observed number of deaths divided by the expected number of deaths. By definition, the mortality ratio of the nonsmokers is 1.00.

Men with a history of only cigarette smoking had by far the highest death rates (as indicated by their high mortality ratios). In age group 40 to 69, the death rate of such cigarette smokers was 79 per cent higher than the death rate of nonsmokers; and in age group 70 to 89 the death rate of such cigarette smokers was 24 per cent higher than the death rate of nonsmokers. (See Fig. 1.)

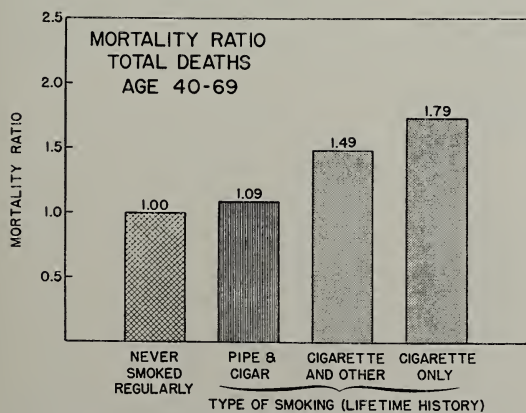


FIGURE 1

The death rate of men who smoked cigarettes and also smoked pipes or cigars (i.e. the "cigarette and other" group) was somewhat lower than the death rate of men who smoked cigarettes only. This is accounted for by the fact that men with mixed smoking habits tend to smoke fewer cigarettes per day and tend to inhale the smoke less deeply than do men who smoke only cigarettes.

The death rate of pipe and cigar smokers was close to the death rate of nonsmokers. This appears to be due to the fact that the great majority of pipe and cigar smokers do not inhale the smoke or inhale it only to a slight degree.

Table 3 shows further details on current cigarette smokers (i.e. men who were smoking cigarettes regularly at the time they enrolled in the study) with a history of only cigarette smoking. It is confined to men between the ages of 40 and 69 for the reason that there were relatively few such cigarette smokers among men in the older age groups. Figures for nonsmokers are included to give a basis for comparison.

The mortality ratio increased substantially with the number of cigarettes smoked per day and was substantially higher among cigarette smokers who said that they inhaled the smoke deeply than among those who said that they did not inhale the smoke. The cigarette smokers who took up the habit before they reached their 20th birthday had higher death rates than did cigarette smokers who started the habit later in life.

Death certificates indicated that coronary artery disease accounted for 698 (47.2 per cent) of the 1,478 deaths. Deaths from this cause were highly associated with the smoking habits of men in age group 40 to 69 but less highly associated with the smoking habits of men in age group 70 to 89. In age group 40 to 69, the coronary artery disease mortality ratios were: 1.00 for men who never smoked, 1.02 for pipe and cigar smokers, 1.60 for men who smoked cigarettes and also smoked pipes or cigars, and 1.84 for men who smoked only cigarettes. The corresponding mortality ratios for men in age group

TABLE 2. *Mortality by type of smoking (lifetime history)*

(Lifetime History)	Age 40 to 69				Age 70 to 89			
	No. of Men	No. of Observed	Deaths Expected	Mortality Ratio	No. of Men	No. of Observed	Deaths Expected	Mortality Ratio
Never Smoked Regularly .....	6,593	162	162.0	1.00	953	157	157.0	1.00
Pipe, Cigar Only .....	3,576	113	103.5	1.09	701	112	116.0	0.97
Cigarette and Other .....	7,822	266	178.5	1.49	437	73	64.4	1.13
Cigarette Only .....	14,520	512	286.8	1.79	461	83	66.8	1.24
Total .....	32,511	1,053	730.8	1.44	2,552	425	404.2	1.05

70 to 89 were 1.00, 0.72, 1.15 and 1.12 respectively. Among cigarette smokers, the death rate from coronary artery disease was related to the degree of inhalation. For example, among cigarette smokers in age group 40 to 69, the mortality ratio was 1.20

the percentages have been standardized for age on the basis of the age distribution of all the men in the study.

The general picture is much the same as that previously shown for total mortality. Only 13.9 per

TABLE 3. *Mortality by amount of cigarette smoking, degree of inhalation and age began cigarette smoking. Age group 40 to 69.*

Current Cigarette Smoking	No. of Men	No. of Observed	Deaths Expected	Mortality Ratio
Cigarettes per day:				
1 - 9 .....	858	28	19.4	1.44
10 - 19 .....	1,949	70	41.0	1.71
20 - 39 .....	6,802	245	123.7	1.98
40+ .....	1,326	47	22.1	2.13
Degree of Inhalation:				
None .....	637	21	16.6	1.27
Slight .....	1,458	58	33.1	1.75
Moderate .....	6,230	217	112.4	1.93
Deep .....	2,604	95	44.5	2.13
Age Began Cigarette Smoking:				
25+ .....	905	26	21.5	1.21
20 - 24 .....	2,545	71	48.2	1.47
15 - 19 .....	5,967	224	106.6	2.10
< 15 .....	1,240	54	24.4	2.21
Never Smoked Regularly .....	6,593	162	162.0	1.00

for those who said that they did not inhale the smoke and 2.27 for those who said that they inhaled deeply.

Lung cancer accounted for 58 deaths (49 in age group 40 to 69 and nine in age group 70 to 89). Three of these 58 men said that they never smoked regularly and five said that they smoked pipes or cigars, but not cigarettes. All of the remaining 50 men who died of lung cancer had a history of cigarette smoking.

Eighteen men died of emphysema. One of these was a pipe smoker and 17 had a history of cigarette smoking.

### Hospitalization

At the time of the second follow-up (approximately two years after the start of the study) surviving subjects were requested to fill out a second questionnaire. On this questionnaire, they were asked whether or not they had been hospitalized since October 1, 1959 (the date the study was started). Of course, non-survivors did not fill out these questionnaires; but we assumed that all those who died had been hospitalized prior to death, this being true in the great majority of cases.

In Table 4, men aged 40 to 69 are classified in groups by their smoking habits as reported on the first questionnaire; and the per cent hospitalized is shown for each of these groups. For comparability,

cent of the men who never smoked were hospitalized within two years while 18.3 per cent of the men with a history of only cigarette smoking were hospitalized during the same period of time. Among current cigarette smokers, the risk of hospitalization increased with amount of smoking from 17.0 per cent

TABLE 4. *Per cent of men hospitalized between start of study and second follow-up (approximately 2 years). Men aged 40-69 at start of study. Percentages are standardized for age on the total population of enrollees in the state.*

Smoking Habits	Per Cent Hospitalized
Never Smoked Regularly .....	13.9
Cigar, Pipe .....	14.7
Cigarette and Other .....	16.3
Cigarette Only .....	18.3
Current Cigarette* .....	18.5
1 - 9 a day .....	17.0
10 - 19 a day .....	16.2
20 - 39 a day .....	19.3
40+ a day .....	20.6
Do Not Inhale .....	17.2
Inhale Slightly .....	16.3
Inhale Moderately .....	18.5
Inhale Deeply .....	21.3
Age Began Smoking:	
25 or older .....	17.7
20 - 24 .....	17.4
15 - 19 .....	18.8
Before age 15 .....	20.8

\*Men with a history of only cigarette smoking who were currently smoking cigarettes at the time of enrollment.



for those who smoked one to nine cigarettes per day to 20.6 per cent for those who smoked 40 or more cigarettes per day. The per cent of men hospitalized was greater among cigarette smokers who said that they inhaled deeply than among those who said that they did not inhale; and was greater among men who started to smoke cigarettes early in life than among those who started to smoke later in life.

### Summary and Discussion

In this paper, we have reported on the smoking habits in relation to the physical complaints of 35,063 Ohio men aged 40 to 89; and have reported the mortality and hospitalization experience of this group of men during the first 34.4 months after they were enrolled as subjects in a prospective epidemiological study. The findings are in good agreement with findings previously reported from other epidemiological studies on this subject.

Cigarette smokers report physical complaints (particularly cough, shortness of breath and loss of appetite) more frequently than nonsmokers, are hospitalized more frequently than nonsmokers, and have far higher death rates than nonsmokers. Among cigarette smokers, the frequency of physical complaints, the frequency of hospitalization and the death rate increase with amount of cigarette smoking, increase with degree of inhalation of the smoke and are higher among cigarette smokers who started to smoke early in life than among those who started to smoke late in life.

As in past studies, death rates from lung cancer, emphysema and coronary artery disease were found to be higher in cigarette smokers than in nonsmokers.

There is no need for us to review the literature

and discuss other evidence on the subject of smoking and health since this has been done many times before. We conclude that cigarette smoking constitutes a major health hazard in Ohio as well as in other parts of the world.

**Acknowledgments:** We would like to thank the 35,063 men who volunteered as subjects for this study; the volunteer workers of the Ohio Division of the American Cancer Society who enrolled and traced the subjects; the Ohio Department of Health that provided us with copies of death certificates; and the many physicians who provided us with additional medical information on subjects who died of cancer.

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**THE ORAL SODIUM TOLBUTAMIDE TEST (OSTT)** for diabetes was significantly different in 102 normal, 21 border-line, and 29 diabetic subjects as classified by the oral glucose tolerance test (OGTT). Mean 30-minute values, in per cent of FBS, were 57.0, 72.3, and 86.2, and mean 40-minute values were 44.1, 60.3, and 79.4 in the three groups, respectively.

Individual agreement between the OSTT and OGTT was generally good, though with some conflicts.

Effective blood levels were attained 10 minutes after oral administration of sodium tolbutamide, 2.0 Gm., and at 20 minutes and beyond, levels exceeded those after intravenous administration of 1.0 gram. Hypoglycemic response to the intravenous and oral tests appeared comparable except for a lag of about 10 minutes and attainment of lower blood sugar levels at 40 and 60 minutes after oral administration. Reproducibility was good, except in those subjects with initial conflict between the OSTT and OGTT. — Thomas J. Vecchio, M. D., David L. Smith, M. D., Harold L. Oster, M. D., and Richard Brill, M. D., *Diabetes*, 13:30-36, (Jan. - Feb.) 1964.

# Acute Plasmacytic Leukemia With Hypercalcemia

## Report of a Case Without Bone Lesions

LEE SATALINE, M. D.

**H**YPERCALCEMIA represents a serious complication of malignant disease, and elevated serum calcium levels resulting from bone destruction by myeloma and metastatic carcinoma have been well documented.<sup>1</sup> More rarely, and less well known, is that hypercalcemia may develop in the apparent absence of bone lesions.<sup>2</sup> This complication has been described with several different tumor types.<sup>3</sup>

Recently, we observed a patient with acute plasma cell leukemia with marked hypercalcemia in whom there was no evidence of bone destruction. Because a review of the literature failed to uncover a similar case and because this case firmly establishes another type of neoplasm associated with hypercalcemia, it is believed worthy of reporting. The bizarre neuropsychiatric symptoms seen in this patient are also noteworthy.

### Case Report

A 57 year old man was admitted because of confusion and maniacal behavior.

His family related that the patient was first found to have hypertension seven years previously, when he had been admitted to another hospital following a crushing injury to his chest. After his discharge, he apparently failed to maintain any form of therapy.

One month prior to his admission, he had reported to the clinic of that hospital because of weakness and anorexia. His blood pressure was recorded as 210/130. The hematocrit was 43 per cent and the white blood cell count 17,700 per cubic mm. with "many abnormal lymphocytes." The blood urea was 26 mg. per 100 ml. The patient was placed on treatment with reserpine, (0.75 mg. daily) and digitoxin, (0.1 mg. daily). No further studies were done.

One week before admission he became lethargic and uncooperative. One day before admission he was found to be extremely somnolent. He was brought to the emergency room of the other hospital but was sent home the same day after his sensorium improved. The family was told he had suffered a "stroke." There was no paralysis. The following morning the patient was incoherent and hostile. A physician was summoned, who referred the patient for admission to the hospital with a diagnosis of "cerebral vascular accident."

Physical examination on admission revealed a confused and hostile man, who otherwise did not appear to be in acute distress. He was well nourished and developed but his skin was dry. His blood pressure was 200/110 mm.

Submitted September 16, 1964.

### The Author

● Dr. Sataline, Lakewood, Ohio, is Director of Medical Education, Lakewood Hospital.

Hg; respiratory rate 20 per minute; pulse rate 100 per minute and regular; temperature 99°F.

The head showed no evidence of injury, and the pupils were equal and responded to light. No corneal abnormalities were seen. Fundoscopic examination revealed narrowing and tortuosity of the vessels, but no hemorrhage, exudate, or papilledema. The buccal membrane and tongue were dry. The ears, nose, and neck were normal. The chest was slightly deformed due to old injuries, but respirations appeared to be symmetrical. The lung fields were clear. The heart was enlarged, and the maximum impulse was felt in the sixth left intercostal space at the anterior axillary line. The aortic second sound was loud and a soft systolic murmur was heard over the apex. The abdomen was soft, and the liver edge was palpated 4 cm. below the right costal margin. No other organs or masses were felt. The rectum and genitalia were normal. There was minimal clubbing of the toes and fingers. The tendon reflexes were hypoactive, but flaccidity was not noted. The cranial nerves appeared to be intact. No abnormal reflexes were elicited. There was no lymphadenopathy.

The admission hemoglobin was 12.5 Gm. per 100 ml., the hematocrit 40 per cent, the white cell count 33,000/cu. mm. with 67 per cent "atypical lymphocytes" and 33 per cent neutrophils. The urine specific gravity was 1.012. It gave a 3 plus reaction for protein and contained 10 to 15 white blood cells per high power field. The blood urea was 40 mg. and the blood sugar 115 mg. per 100 ml. Serum electrolytes were within normal limits. The electrocardiogram was compatible with left ventricular hypertrophy and digitalis effect. Heart rate was 85 with sinus rhythm, and the QT interval was normal. A lumbar puncture produced clear spinal fluid under normal pressure, and the routine microscopic and chemical examinations were within normal limits. Skull x-rays were normal. Adequate fluid intake was maintained with glucose and electrolyte solutions. The patient's clinical picture remained unchanged during the next 36 hours. His urinary output was 450 cc. in 24 hours.

On the third hospital day, the hemoglobin was unchanged but the white cell count increased to 42,000/cu. mm. with 66 per cent "atypical" lymphocytes, many of which resembled plasma cells (Fig. 1). The platelet count was normal. The urine contained 4 plus protein and 10 to 15 white blood cells per high power field. Bence-Jones protein was absent, but urine electrophoresis revealed a sharply defined peak in the mobility range of beta globulin, as well as a smaller albumin peak. The blood urea was



58 mg. per 100 ml. The alkaline phosphatase, serum cholesterol, and serum protein electrophoretic pattern were normal. The Sia water test for macroglobulins, as well as the test for cryoglobulin, were negative.

Bone marrow examination revealed a hyperplastic marrow. Within the islands of immature erythrocytic and granulocytic cells were dense infiltrations of small round cells with clear cytoplasm and eccentric nuclei. The chromatin of the nucleus was dense and arranged in a cart wheel fashion. The hematologist believed these cells were plasmacytic in type. A roentgenogram of the chest showed old, healed fractures of the ribs and some left ventricular enlargement. X-rays of the long bones, hands and spine revealed no osteolytic lesions, and bone density appeared normal.

Because the patient's neuropsychiatric manifestations were unexplained, a serum calcium determination was obtained. The calcium was 17.4 mg. and the phosphates 12 mg. per 100 ml. The patient's family was interrogated again in an attempt to detect a possible exogenous cause for the hypercalcemia. Specifically, excessive alkali, calcium, and vitamin D ingestion were denied. As there was no other apparent cause, the hypercalcemia was thought to be secondary to the neoplastic process. In an attempt to reduce the calcium level, 300 mg. of cortisone in the form of Solu-Cortef® was given daily by means of intravenous infusions. While the use of alkylating agents was considered, it was felt that the increased nitrogen load resulting from the destruction of the leukemic cells would further aggravate the renal problem. Because of its possible nephrotoxic effect, ethylenediaminetetracetic acid (EDTA) was not used.

By the fifth day, the daily urinary output was 800 cc. and the urinary calcium 250 mg. The serum calcium was 16 mg. per 100 ml. The patient was able to take sips of water but intravenous fluids with Solu-Cortef (300 mg. daily) were continued. A repeat electrocardiogram showed

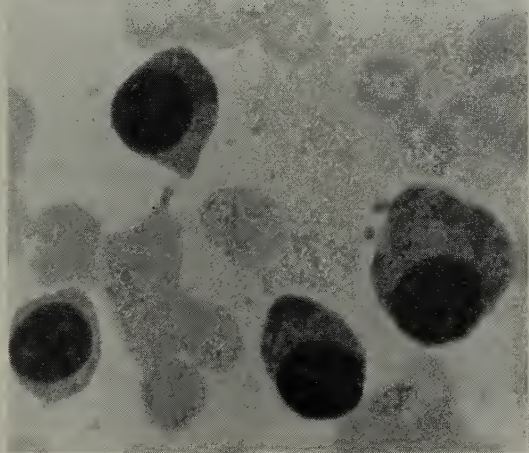


FIG. 1. A photomicrograph of the peripheral blood demonstrating lymphocytes and plasma cells (original magnification  $\times 1000$ ).

no change. His blood pressure ranged between 180 to 200 mm Hg., systolic and 105 to 120 mm Hg., diastolic.

On the seventh day the white blood cell count was 65,000/cu. mm with 49 per cent plasma cells, 20 per cent lymphocytes, and 31 per cent neutrophils. The blood urea was 81 mg. per 100 ml., but serum electrolytes remained normal. The serum calcium fell to 15 mg. while the phosphorous rose to 16 mg. per 100 ml. The daily urinary output fell to 680 cc. The patient again became stuporous.

From this point on, the patient's condition steadily deteriorated. Urinary output remained less than 500 cc. daily with a 24 hour calcium content of less than 150 mg. The cortisone infusions were continued. On the morning of the tenth hospital day, "uremic frost" was noted, and the patient was deeply comatose. He died quietly a few hours later. Terminally, the blood was 94 mg., the serum

calcium 14 mg., and the phosphorous 18 mg. per 100 ml. The hemoglobin was 12 Gm. per 100 ml., and the white blood cell count was 121,000/cu. mm., with 67 per cent plasmacytes, 18 per cent lymphocytes, and 15 per cent neutrophils.

### *Autopsy and Microscopic Findings:*

Postmortem examination was performed two hours after death. Pertinent gross findings were as follows. The lungs were subcrepitant, edematous, and several patches of bronchopneumonia were observed bilaterally. The heart weighed 500 grams with the left ventricle markedly hypertrophied. The liver weighed 2,000 grams, and the spleen weighed 275 grams. Both appeared congested. The right kidney weighed 220 grams and the left 350 grams. The corticomedullary ratio appeared normal. The brain was edematous, but repeated serial sections showed no gross areas of infarction or softening. All major vessels were patent. Four parathyroids were identified and appeared normal.

Microscopically the lungs revealed marked congestion with foci of bronchopneumonia. Dark calcific precipitates were observed within the walls of the alveolar septa. The liver contained many abnormal plasma cells packed in the portal areas and along the sinusoids. The spleen also showed a diffuse infiltration of plasma cells into the sinusoids, but no aggregates of these cells were observed. The renal tubules showed cloudy degeneration and contained numerous foci of metastatic calcification. Casts of densely eosinophilic proteinaceous material were seen within the lumens. Small foci of plasma cells were scattered throughout the kidney parenchyma. Microscopic examination of the parathyroids revealed no abnormalities. Metastatic calcification deposits were also noted in the brain, pituitary, and adrenal glands. Random bone biopsies demonstrated abnormal cells only within the marrow. No osteolytic lesions were noted.

### *Discussion*

The hypercalcemia associated with neoplastic destruction of bone has been previously considered to result from the released calcium exceeding the kidneys' capacity to excrete it.<sup>1</sup> More recently, however, the validity of this concept has been challenged,<sup>4</sup> and the exact mechanism remains uncertain. The manner in which hypercalcemia develops in the absence of bone destruction is also unknown. Some authors speculated that the tumor secretes a parathyroid hormone or vitamin D-like substance,<sup>2,5</sup> but these theories have never been substantiated. In these cases it is unlikely that the hypercalcemia results from numerous minute osteolytic lesions, since removal of the primary tumor mass has resulted in a decrease in the serum calcium levels in several instances.<sup>2</sup> Furthermore, the hypercalcemia has been known to occur with neoplastic diseases, which generally are not associated with massive bone destruction (e.g. lymphoma, Hodgkins disease).

There have been four previous reports of the association of leukemia and hypercalcemia.<sup>6-9</sup> Lymphocytic leukemia was present in two cases<sup>7,8</sup> and myelocytic leukemia in one.<sup>8</sup> No cell type was described in the fourth.<sup>6</sup> In two cases<sup>7,9</sup> however, bone lesions were described. Cortisone reduced the elevated serum calcium in two instances<sup>7,9</sup> and was apparently ineffective in a third.<sup>8</sup>

The skeletal, renal, and gastrointestinal symptoms of hypercalcemia have been well emphasized in the literature, but the neuropsychiatric manifestations associated with elevated serum calcium levels have

received relatively less attention. Psychosis, depression, irritability, apathy, and lethargy may be prominent symptoms of hypercalcemia,<sup>10,11</sup> and these neuropsychiatric manifestations reportedly occur in more than 40 per cent of the patients.<sup>11</sup> Although there is usually no correlation between the severity of the symptoms and the serum calcium level, there occurs an acute or extreme degree of hypercalcemia, in some instances, which produces a "hypercalcemic crisis." Profound weakness, dehydration, and delirium develop, and if not immediately and vigorously treated, coma, uremia, and death rapidly ensue. The present case well illustrates this tragic sequence of events.

The role of calcium in the neural processes has been only partially clarified. The calcium ion alters neurone excitation, with hypocalcemia increasing and hypercalcemia depressing neuronal excitability.<sup>12,13</sup> It is believed that elevated calcium ion concentrations, by increasing the electrical resistance of the cell membrane, reduce depolarization and thus block the transmission of the nerve impulse.<sup>12</sup>

When hypercalcemia is detected, the calcium intake should be restricted and fluids forced in order to maintain an adequate urinary flow. Corticosteroids in large doses are effective in lowering the calcium levels in the majority of cases of non-parathyroid induced hypercalcemia.<sup>14</sup> Failure to reduce the hypercalcemia with corticosteroids may indicate irreversible renal impairment.<sup>15</sup> A chelating agent such as ethylenediaminetetracetic acid (EDTA) may be administered but its effect lasts only a few hours, and because it is excreted via the kidney, renal function may be further compromised. As the hypercalcemia is secondary to the neoplastic growth, surgical excision, radiation therapy, or treatment with antitumor drugs may reduce the elevated calcium levels. However, the hypercalcemia may reappear with recurrence of the tumor.

In any form of malignant disease, hypercalcemia must always be considered a possible complication,

especially when bizarre and unexplained neuropsychiatric symptoms develop. As demonstrated by this case, bone lesions need not be present. Prompt detection and treatment with corticosteroids are imperative.

### Summary

Hypercalcemia may occur in many forms of malignancy even in absence of osseous lesions. A case of acute plasmacytic leukemia without apparent bone involvement and complicated by a marked hypercalcemia is described. The cause of hypercalcemia in these cases is unknown. Gastrointestinal, renal, skeletal, and neuropsychiatric symptoms may occur with elevated serum calcium levels. When hypercalcemia is detected, prompt treatment with fluids and corticosteroids is imperative.

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**I LIOFEMORAL VEIN THROMBOSIS.**—Nine patients with massive thrombosis of the iliac and femoral veins have been recognized in the past three years at the University of Oklahoma Medical Center. Iliofemoral thrombectomy has been a simple procedure in seven patients and the early results are satisfactory.

Death occurred in two patients, one due to shock and the other to pulmonary embolism before iliofemoral thrombectomy could be carried out. Immediate thrombectomy should be considered in every case of massive iliofemoral venous thrombosis and almost certainly represents an important advance in the treatment of this condition.—G. Rainey Williams, M.D., B. P. Loughridge, M.D., W. E. Price, M.D., and Gilbert S. Campbell, M.D., Oklahoma City: *The Journal of the Oklahoma State Medical Association*, 57:143-148 (April) 1964.



# Pulmonary Hypertension

## Report of a Case in Association with Rheumatoid Arthritis\*

SEIJU ONODERA, M.D., and JAMES R. HILL, M.D.

PULMONARY arteritis in rheumatoid arthritis has infrequently been reported. Our patient who had a typical clinical picture of rheumatoid arthritis died of right-sided heart failure at the age of 15 years. The necropsy disclosed intimal proliferation of pulmonary arteries and arterioles, and marked dilatation and hypertrophy of the right ventricle apparently caused by pulmonary hypertension. A review of the English literature for the past 20 years revealed a similar case report of a young woman by Gardner et al. in 1957.<sup>1</sup> In 1960 Rawson and Woske reported four cases of primary pulmonary hypertension two of which had arthritis.<sup>2</sup> The association of rheumatoid arthritis with pulmonary hypertension seems of considerable interest and we will report a further case.

### Case Report

**First Admission:** (June 22, 1960.) A 12 year old colored girl entered the hospital because of aching and swelling of the fingers, wrists, and ankles. She had been well until about the age of 8 years, when she began to experience stiffness and aching in the fingers and wrists. For the previous two years she had tired very easily. She had been able to play with other children for only short intervals before tiring.

Physical examination revealed a thin girl who appeared younger than her age. She showed ulnar deviation of both wrists and fusiform swelling of the interphalangeal joints. No other joint deformity was visible, although she complained of pain in the temporomandibular, knee, and ankle joints. The lungs were clear. Auscultation of the heart revealed a regular sinus rhythm, a grade 2 pulmonary area systolic ejection murmur and split second sound with normal respiratory movement. The abdomen was flat with the liver palpable 3 cm. below the right costal margin. The spleen edge was palpable. Her temperature was 99.4°F., pulse rate 100 per minute, respiratory rate 18 per minute, and blood pressure 105 systolic, 70 diastolic.

The urine was normal. The hemoglobin was 11.2 Gm. per 100 ml., white blood cell count was 7800 per cu. mm. with 66 per cent neutrophilia, C-reactive protein 1 plus, latex-fixation test negative, erythrocyte sedimentation rate 37 mm. per hour (Wintrobe), antistreptolysin titer 50 Todd units, L-E preparation negative.

The chest x-ray showed slight enlargement of the heart and prominence of bronchovascular markings. An electrocardiogram was interpreted as within normal limits. X-ray films of the hands and wrists revealed considerable osteoporosis of the bones of both hands, and narrowing of metacarpophalangeal and interphalangeal joint spaces. The diagnosis of rheumatoid arthritis in a juvenile was made.

She was treated with acetylsalicylic acid, adrenal corticosteroid, and physiotherapy. These were continued almost to her death. In addition, she received chloroquin intermittently.

### The Authors

● Dr. Onodera, Baltimore, Maryland, is Research Fellow, Division of Arthritis, Department of Medicine, University of Maryland, Baltimore; formerly, Medical Resident, the Youngstown Hospital Association, Youngstown, Ohio.

● Dr. Hill, Youngstown, is Associate Pathologist, the Youngstown Hospital Association.

**Second Admission:** (January 30, 1961.) She was admitted because of recurrent attacks of pain in the joints and increasing weakness of the hands, although she had been followed at the outpatient department. X-ray of the hands and wrists (fig. 1) revealed subluxation of almost all phalanges and marked diminution of carpal joint spaces.

**Third Admission:** (February 20, 1962.) By now she was exhibiting multiple joint deformities and muscular atrophy. Ten days prior to admission she developed a cough and slight fever. Râles were heard over the right lower lung. The liver extended 5 cm. below the left costal margin. A chest x-ray revealed marked prominence of the pulmonary artery segment of the cardiac silhouette and marked increase of bronchovascular markings. The patient was given tetracycline, and the cough and fever subsided. After discharge a repeated chest x-ray at the outpatient department (fig. 2) showed persistent prominence of pulmonary artery segment.

**Fourth and Final Admission:** (September 16, 1962.) Because of fatigue and abdominal distention the patient was

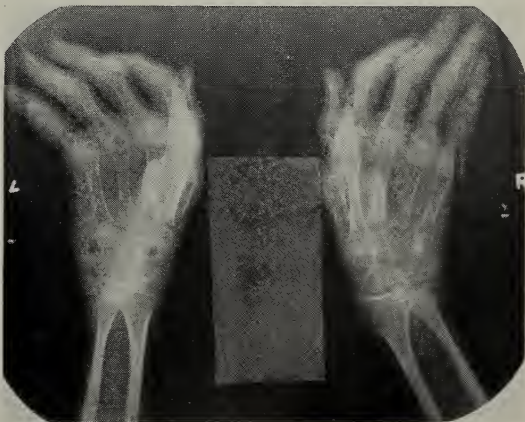


FIG. 1. Demineralization of the bones of both hands, subluxation of almost all phalanges, and marked diminution of carpal joint spaces.

\*From the Department of Medicine, and the Department of Pathology, the Youngstown Hospital Association, Youngstown, Ohio. Submitted August 12, 1964.



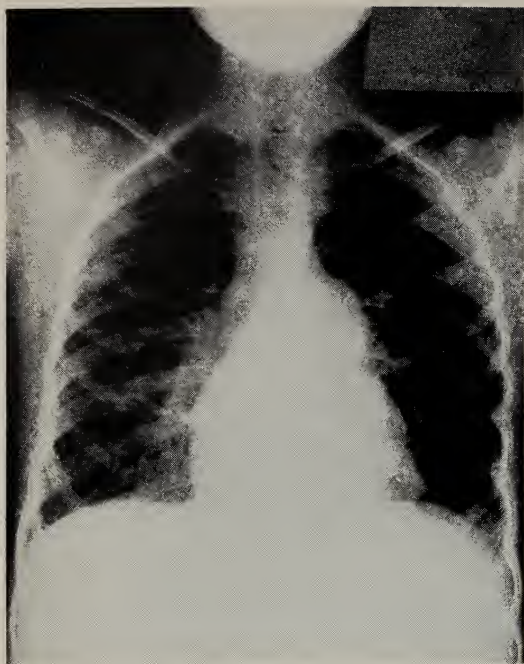


FIG. 2. Marked prominence of pulmonary artery segment of cardiac silhouette.

again hospitalized. She was chronically ill and underdeveloped for her age of 15 years. The jugular venous pulse revealed giant "a" waves. Arterial pulses were small. A right ventricular heave was palpable and visible along the left sternal border. The second heart sound was palpable in the pulmonary area. On auscultation there was a grade 1 systolic ejection murmur and loud second sound at the pulmonic area. The second sound was widely split, but moved slightly in a normal fashion with respiration. Crepitant râles were heard at the right lung base. The abdomen was very distended. The liver was tender and palpable 12 cm. below the right costal margin; the spleen 7 cm. below the left costal margin. No pedal edema was present. The temperature was 98.0°F., pulse rate 120 per minute, respiratory rate 26 per minute and the blood pressure 100 systolic, 70 diastolic.

The urine showed a trace of protein. The red blood cell

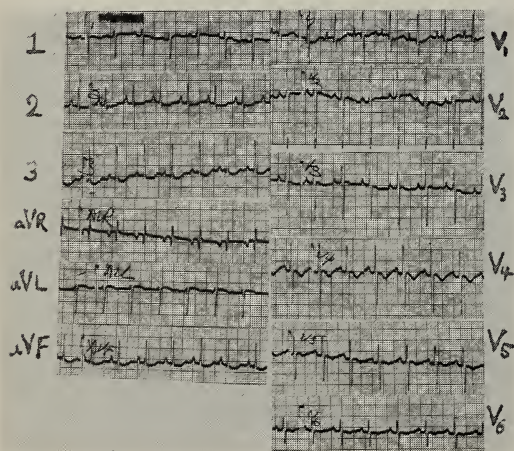


FIG. 3. Right ventricular hypertrophy pattern and spiked P waves.

count was 4.2 million per cu. mm., hematocrit 29.5 per cent and the hemoglobin 9.3 Gm. per 100 ml. The reticulocyte count was 2 per cent. Total serum protein was 8.36 (albumin 3.79 and globulin 4.57) Gm. per 100 ml. Total bilirubin was 0.95 mg. per 100 ml., prothrombin time 25 per cent of normal, cephalin flocculation 4 plus and serum glutamic oxalacetic transaminase (SGOT) 195 units. Protein-bound iodine was 4.2 micrograms per 100 ml. Blood urea nitrogen was 17 mg. per 100 ml. and fasting blood sugar 70 mg. per 100 ml. A latex-fixation test was positive. Antistreptolysin titer was 12 Todd units.

The electrocardiogram (fig. 3) showed sinus tachycardia, right ventricular hypertrophy, and peaked P waves in leads II, III, aVf, V<sub>1</sub>, V<sub>2</sub>, and V<sub>3</sub>.

During the hospital course a liver biopsy was performed because of a suspicion of primary liver disease. It showed acute passive congestion. Pedal edema gradually appeared. Cough became frequent and she became short of breath. Râles at the lung bases increased. Chest x-ray at this time (fig. 4) revealed that the heart was more enlarged. Therapy was begun with digitalis and diuretics. Her condition, however, continued to deteriorate. High doses of corticosteroid were given as a desperate measure. On November 10, 1962, she suddenly developed generalized convulsions and died in a few minutes.

### Postmortem Findings

Autopsy revealed a markedly cachectic, small female child appearing much younger than her stated age. There was

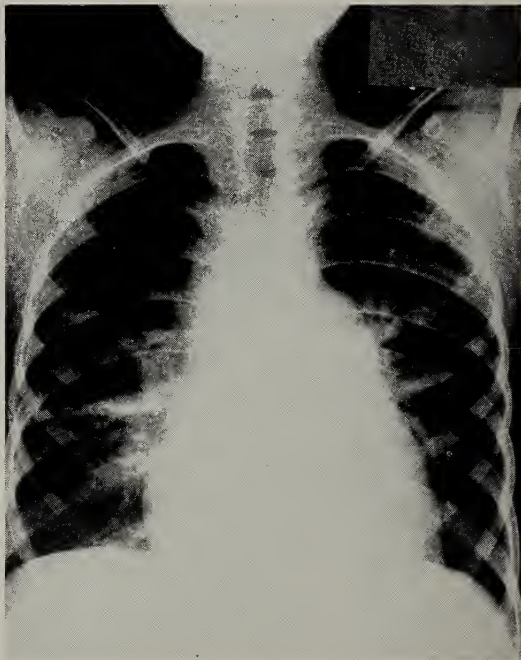


FIG. 4. Further enlargement of the heart and persistent prominence of pulmonary artery segment.

prominent thickening of the joints of the hands, wrists, elbows, and feet. The abdomen was moderately distended with peritoneal cavity containing 500 ml. of clear serous fluid. The liver extended 6 cm. below the right costal margin (the diaphragm was at the fourth rib interspace) and weighed 1330 grams. The liver was dark brown and firm in consistency. The spleen was congested and weighed 300 grams. The adrenal glands were atrophic. The other abdominal organs appeared unremarkable.

Upon opening the thorax, there was bilateral focal fibrinous pleuritis with the right pleural cavity containing 500 ml., the left 300 ml. of serofibrinous fluid. The lungs had a grossly normal appearance with the right weighing 350



grams and the left 260 Gm. On palpation, they were diffusely firm and did not have the normal crepitation. The heart was enlarged due primarily to right atrial and ventricular dilatation and hypertrophy (right ventricle 0.7 cm. in thickness). There was focal fibrinous pericarditis. The larger pulmonary arteries were grossly unremarkable.

On microscopic examination, the positive findings were limited almost entirely to the lungs. They showed a diffuse mild interstitial and perivascular fibrosis and severe intimal proliferation involving almost all of the small arteries and arterioles. The medial and adventitial layers were not involved (fig. 5 and fig. 6). These vascular changes did not involve any other organ.

Other microscopic findings were focal acute pericarditis, severe hepatic congestion and fatty metamorphosis, marked adrenal cortical lipid depletion and splenic and renal congestion.

Permission for examination of the joints was not obtained.

### Discussion

Previous generations of physicians were not greatly impressed with the systemic nature of rheumatoid arthritis. However, recent reports have disclosed numerous alterations of internal organs in this disease.<sup>3</sup> Increasing attention has been focused on vasculitis as one of these visceral changes occurring in patients with rheumatoid arthritis, although the relationship between this vascular lesion and adrenal corticoid therapy has been raised.<sup>4,5</sup>

The location of this rheumatoid arteritis apparently varies from case to case. In some, it involves arteries in the extremities, causing skin ulcers, gangrene and peripheral neuropathy,<sup>4,5</sup> and in others it attacks visceral arteries, resulting in infarction of intestines.<sup>6,7</sup>

Involvement of pulmonary arteries by rheumatoid vasculitis is rare. However, the review of literature discloses such occurrences.<sup>8,9</sup> So long as rheumatoid vasculitis is regarded as a manifestation of rheumatoid arthritis, there seems to be no reason for the pulmonary arteries to escape this arteritis.

The idea that pulmonary arteritis may contribute to pulmonary hypertension is by no means new. In 1956 Könn reported in German his extensive pathological study on 52 cases of chronic cor pulmonale. As one of the lesions which caused pulmonary hypertension, he mentioned one case of pulmonary panarteritis in rheumatoid arthritis.<sup>10</sup> Also in 1956 Wade and Ball illustrated 10 cases of unexplained pulmonary hypertension, eight of which were subjected to cardiac catheterization. One of these patients had rheumatoid arthritis, but whether this patient had pulmonary arteritis is not certain, since the patient was still alive.<sup>11</sup>

Gardner et al. were the first, as far as can be determined by review of English literature, to describe in detail a case of rheumatoid arthritis in which pulmonary hypertension developed and in which severe intimal proliferation of pulmonary arteries was seen. Their patient had vasculitis of digital arteries in addition to pulmonary arteritis.<sup>1</sup> Like their case, our patient had a typical clinical picture of rheumatoid arthritis exhibiting deformities of wrists and fingers and muscular atrophy. X-ray and laboratory findings were compatible with the diagnosis of Still's disease,

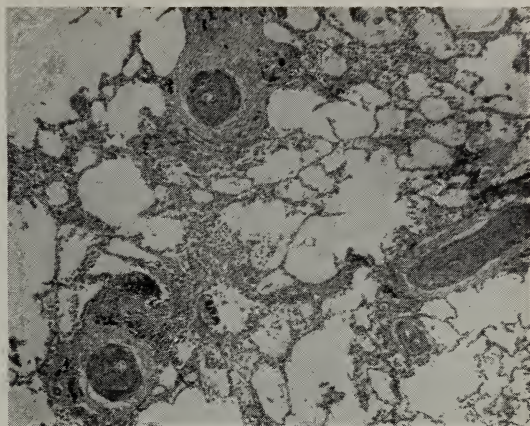


FIG. 5. Magnification X 35. Marked generalized involvement of all small pulmonary arteries and arterioles with severe intimal proliferation.

but her marked hepatomegaly remained unexplained until cor pulmonale was diagnosed. The clinical picture indicated that she had pulmonary hypertension, but her condition was too grave to permit cardiac catheterization and further studies.

The possibility still remains that this change in pulmonary arteries and arterioles was the result rather than the cause of pulmonary hypertension.<sup>12,13</sup> If this were the case, this patient would have had both rheumatoid arthritis and primary pulmonary hypertension. We believe that this intimal proliferation in our patient is due to rheumatoid vasculitis.

Rawson and Woske described four cases of primary pulmonary hypertension. Two of these patients had arthritis and Raynaud's phenomenon, and they suggested the relation of primary pulmonary hypertension to collagen diseases.<sup>2</sup> Pulmonary hypertension is still a mystery as well as systemic hypertension, but apparently many factors contribute to it.<sup>14,18-20</sup>

It is interesting that the present case also had mild pulmonary fibrosis, fibrous pleuritis, and fibrous peri-

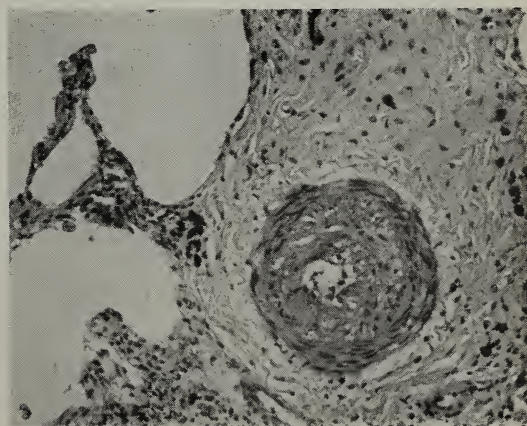


FIG. 6. Magnification X 120. Higher power to show the severe intimal proliferation with almost complete obliteration of the lumen.

carditis, all of which have been described as occurring in rheumatoid arthritis.<sup>9,15-17</sup>

### Summary

This is the report of a patient with rheumatoid arthritis, who developed the clinical picture of pulmonary hypertension. The necropsy revealed severe intimal proliferation of small pulmonary arteries and arterioles, which we regard as rheumatoid vasculitis. The systemic character of rheumatoid arthritis and rheumatoid vasculitis were discussed. Association of pulmonary hypertension with collagen diseases was mentioned.

**Acknowledgments:** We are indebted to Dr. Frederick S. Coombs, Jr., Dr. William D. Loeser, and Dr. James L. Calvin for their many helpful suggestions, and to Mrs. Willard Wright for preparing the photographs.

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**T**RANQUILIZING DRUGS are misnamed and show broader effects than previously suspected. New evidence indicates that the phenothiazines, the most widely used of the "tranquilizers," improve the passive, withdrawn, apathetic patient even more than the agitated, abusive one. The drugs' action, therefore, is broader and more versatile than is presently outlined in standard medical texts.

In a nine-hospital collaborative study of 340 patients, the following symptoms, which are considered fundamental to schizophrenia, were the most improved by the phenothiazines: poor social participation, poor self-care, confusion, indifference to environment, and hebephrenic gestures (grimacing and giggling). Psychiatric teams which evaluated patients with these symptoms after six weeks of drug therapy found them markedly improved. In contrast, hostility, agitation, anxiety, and ideas of persecution—symptoms which are usually regarded as 'target symptoms' for tranquilizing therapy—although influenced by the drug treatment, were not affected to as great a degree.

The drugs were shown to act in two ways: they alleviated the patient's pre-treatment symptoms and prevented the development of other schizophrenic symptoms the patient did not have before treatment. The drugs seem to have a general alleviating and preventive anti-schizophrenic action and can be used appropriately for a wide variety of schizophrenic patients.

This finding reported at a V.A. Psychiatric Conference held recently in Kansas City, by Dr. Jonathan C. Cole, Director, Psychopharmacology Service Center, National Institute of Mental Health, Bethesda, Maryland.



# Late Result of Renal Injury

## Report of a Case

R. ROMAN, M. D.

THE speed and violence of modern day living, recreation, and transportation make the renal injury a common condition today. While there have been many papers on opinion, cause, detection and treatment of such injuries, some aspects remain unclarified.

One of the most difficult decisions for the urologist is whether to manage renal injuries conservatively or surgically. Each case, of course, must be treated individually; and the doctor's opinion may change as treatment progresses. Opinions vary from one extreme of surgically exploring all patients, to the other extreme of treating conservatively, practically all patients.

Proponents of early surgical exploration point out the possibility of late sequelae such as infection, hydronephrosis, liquefaction necrosis,<sup>1</sup> perirenal hematoma, hypertension,<sup>2</sup> infarction,<sup>3</sup> atrophy, arteriovenous fistula,<sup>4</sup> and others. Those advocating conservative management believe that most surgical explorations are unnecessary and may end with nephrectomy. They hope that they will have a better chance of saving some functioning renal tissue in being conservative.

A presumptive diagnosis of renal injury is justified when there is a history of trauma to the kidney area followed by hematuria. Many minor renal injuries are overlooked because a urinalysis is not done at once.

There are three categories of renal trauma<sup>5</sup> that I have found very useful in evaluating decisions of treatment: (1) minor injuries; (2) major injuries; and, (3) critical injuries. The difficult decision will be in the first category, minor injuries; when believing that the lesion is an innocent one, later on a sequela is found bad enough to produce a crippling condition. In the last two categories surgical intervention should be done, and I believe that this is very generally accepted. Of course, sometimes it is difficult to classify the trauma.

Because of the possibility that an additional lesion may have existed prior to renal injury, proper management of the patient should not end simply with the first aid and emergency procedures. Mild trauma may cause renal tumors to bleed, for example. A

### *The Author*

● Dr. Roman, Columbus, is a member of the staff, Department of Urology, St. Anthony Hospital.

safe conduct on all patients with renal trauma should be a follow-up physical examination and a pyelogram every 6 to 12 months.

### *Case Report*

A late unexpected sequela will be illustrated in the following case:

A 35 year old white man had an automobile accident three years prior to his first visit to my office. In this accident he injured his right thumb and received multiple contusions on the trunk, for which he was taken to a hospital emergency room. Physical examination revealed multiple bruises on different parts of the trunk. He was treated symptomatically and discharged.

Several hours later, he had an episode of gross hematuria. The following day the urine was grossly clear and he did not procure further medical attention.

In early March 1964, he was referred to me by his family physician because for the past one month he was having recurrent episodes of pain in the right flank radiating down to the corresponding testicle. On certain occasions the pain radiated to the middle aspect of the right thigh.

Physical examination was not remarkable except for a possible right subcostal mass and blood pressure of 160/90 mm. Hg.

Intravenous and retrograde pyelograms revealed a non-functioning, hydronephrotic right kidney and a normal left kidney. Nephrotomogram showed a mass displacing the right kidney laterally. Chest x-rays, films of the lumbosacral spine, and barium enema were negative.

Through a right subcostal, anterior, abdominal, transperitoneal approach, the kidney with a cyst attached was removed. The dissection of this mass was surgically difficult because the vena cava lay over the mass and was firmly attached to it.

### *Pathologist's Report*

*Gross:* The specimen weighed 571 Gm. and measured 15 by 10 by 8 cm. On sectioning, a 10 cm. cyst containing semi-liquid and partially clotted brown material is encountered which lies outside the dilated renal pelvis and over which the ureter courses.

*Microscopic:* The sections of the cyst wall show it to have contained old blood. At the periphery there is some evidence of organization. The wall itself is composed of dense fibrous tissue showing patchy lymphocytic and plasma cell infiltration. There is no evidence of neoplasia. There is no identifying epithelium. Sections of the kidney reveal

Submitted June 17, 1964.

glomeruli showing fibrosis of Bowman's capsule. The stroma shows patchy fibrosis and lymphocytic infiltration.

*Diagnosis:* (1) Encapsulated Hematoma, (2) Hydronephrosis, (3) Chronic Pyelonephritis.

\* \* \*

The patient had an uneventful recovery. The blood pressure varied from 130/75 to 160/90 mm. Hg. during hospitalization. Postoperatively, five months after surgery blood pressure was found to be 125/75 mm. Hg suggesting the Goldblatt syndrome.

### Summary

The problem of conservative versus surgical management of renal injuries has been discussed briefly. A case has been presented of a post-traumatic sequela. In this case the crippling effect was out of proportion to the apparent initial trauma. The length and severity of the hematuria did not appear to bear any

relationship to the severity of the injury or to the subsequent course of the patient.

This is again a good example that a physical examination and a pyelogram follow-up every 6 to 12 months should be done for at least two years after renal trauma.

289 East State Street, Columbus, Ohio 43215.

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ON THE SIDE OF THE GODS.—Recently, we disputed Dr. Robert W. Kistner's spelling of PROGESTAGEN in the manuscript of his paper.<sup>1</sup> Supported by every dictionary at our disposal, we changed the spelling to PROGESTOGEN. Editors are accustomed not only to having their judgment challenged but also to overruling the challenge. However, when Dr. Kistner solicited the support of Dr. William B. Ober\*, all controversy ceased. In order to return to the side of the Gods, where all good editors belong, we herewith reprint Dr. Ober's delightful spelling lesson.

"Robert W. Kistner, M. D.

"32 Cumberland Avenue

"Brookline 46, Mass.

"28 October 1964

"Dear Bob,

"Yes, you are perfectly right. Progestagen is spelled with an *A* not an *O*. The dictionaries are etymologically incorrect. However, in the forthcoming edition of the American College Dictionary and in the 24th edition of Dorland's it will be spelled with an *A*.

"As I pointed out in Acapulco, its central stem is from *gestare*, to bear. The root *gesta-* ends in the strong *A* of the first conjugation, hence progestAYtional, never progestOhtional. To the Spanish speaking members of the audience in Acapulco, this was quite obvious, as their language uses the word *progesta'genos*, and the accent is on the *A*.

"The original mistake came about when some American tried to coin a word to match estrogen and androgen by adding the suffix *-gen* (causing, producing) to the basic stem. Whoever it was, he did not recognize that *estro + gen* and *andro + gen* are easy coinages with both parts of the recently formed words being of Greek origin. It is not so easy when one adds the Greek suffix *-gen* to the basic Latin root *gesta-*. One has to keep in mind that the stem is *gesta-* (not *gest-*) and that the suffix is *-gen* (not *-ogen*).

"Now an etymologic purist might argue that the forced marriage of a Latin root to a Greek suffix is basically a false relation. If this were 1864 not 1964, I could go along with that view. But in the formation of scientific neologisms during the past century it has become permissible, even proper, to mix Latin and Greek. Consider such a word as *polyvalent* which has won out over *multivalent*, etymologically purer.

"Please ask Dr. Ayres to stick to PROGESTAGEN and he will be on the side of the Gods. Some people are more sensitive to minutiae like this than others. When I see it spelled PROGESTOGEN, it is like hearing chalk on the blackboard or hearing a soprano reach for a high note and miss it badly.

"Sincerely yours,

"WILLIAM B. OBER, M. D."

<sup>1</sup>Kistner, Robert W.: Hazards of Obstetrical and Gynecological Drugs. *Ohio State Medical Journal*, 60:1125-1129, (Dec.) 1964.

\*Director of Laboratories, Knickerbocker Hospital, 70 Convent Avenue, New York 27, New York.



# Correctable Renal Hypertension

## XI. Surgical Treatment (concluded)

CHESTER C. WINTER, M.D.\*

EXCELLENT results from partial or total nephrectomy for unilateral pyelonephritis may be expected to range from 20 to 50 per cent. Smith's review in 1948 found that nephrectomies resulted in the former rate, and in 1956 a second survey showed the rate to be improved to 26 per cent. In the next year, Thompson reported that removal of an unilaterally atrophic pyelonephritic kidney satisfactorily reduced blood pressure in 50 per cent of such patients, but in only 25 per cent of all renal hypertensive patients, regardless of atrophy. At the present time most physicians concede that after surgery a 40 to 50 per cent cure rate for pyelonephritis may be expected with another 20 or 30 per cent of patients improved.

A higher percentage of cured and improved patients is claimed for the results of reconstructive renovascular surgery. The incidence of complete recovery has varied from 40 to 82 per cent of patients according to various authors. Many urologists and vascular surgeons believe that a 40 to 50 per cent cure rate is more in keeping with the average results and that another 20 to 30 per cent of patients will be improved. In 1962, Dustin and Page reported the results of 102 operations for renal artery disease causing hypertension. They found that 56 per cent became normotensive and 22 per cent more had been benefited; among the remaining 22 per cent they included the deaths (10 per cent). Morris considered 82 per cent cured in his series of 115 patients subjected to renal artery surgery, but his definition of cure included a return of blood pressure to a level commensurate with age. An additional 8 per cent of his patients were improved, while 10 per cent were unimproved, including seven patients who died postoperatively.

Some patients may have to undergo further renal or renal artery surgery because of postoperative complications or the discovery or development of new lesions. It is important, therefore, to follow post-

operative patients carefully in respect to their kidney function as well as to their general physical condition. Perhaps the most useful tests in follow-up examinations are the radioisotope renogram and the excretory urogram. The former depicts comparative vascular and functional capacity, and provides an index of the ability of the kidney to evacuate urine. The urogram supplies information about renal size, shape and internal architecture. Both tests are invaluable for comparisons with preoperative tests and progressive lesions are readily detected.

Some patients unresponsive to antihypertensive drugs prior to surgery become more reactive to medication after corrective operative procedures. It is possible that the role played by the renin-angiotensin mechanism in hypertension applies primarily to the acute stage and that an additional neurogenic mechanism is involved in the chronic phase. Thus, surgery may serve to obliterate the humoral factor and allow drugs then to become capable of controlling the neurogenic element. Some investigators believe that the carotid sinus plays an important role as a baroreceptor in this respect.

It is not unusual for the repaired kidney to show a return of function greater than its unaffected mate. Although older explanations infer that renal counterbalance may be responsible this may be ascribed to the protection afforded the kidney from the evil effects of hypertension by the constricting lesion, while the unrestricted blood pressure in the contralateral kidney produces irremediable vascular changes. Occasionally, therefore, after a kidney is revascularized and returned to normal function but with a maintenance of vascular hypertension, removal of the contralateral, previously unaffected, kidney may be indicated. However, this possibility interjects a controversial issue to be reviewed with great reservation.

The next and final article in this series will deal with prognostic factors related to renal hypertension.

### Reference

*Correctable Renal Hypertension*, Philadelphia, Lea and Febiger, 1964.

\*Dr. Winter, Columbus, is Professor of Surgery and Director of Division of Urology, The Ohio State University Hospitals.

# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT G. THOMAS, M. D., *President*

## PRESENTATION OF CASE

THIS white man, aged 49, was admitted semicomatose; the only history was supplied by the referring physician. The patient was apparently well until four weeks before admission when he developed thrombophlebitis in his right leg. He was treated with Achromycin® and Chymoral® with some improvement. At about the same time he noted the onset of cramping epigastric pain with diarrhea, later associated with fever, chills, postural hypotension, and syncopal attacks.

He was admitted to his local hospital with a temperature of 103°F. The only positive physical findings there were a liver palpable 6 fingerbreadths below the right costal margin and possible enlargement of the spleen. The white blood cell count was 20,250, hemoglobin 9 Gm. Three days later the hemoglobin was 3.1 Gm. The total bilirubin was reported as 4 mg. per 100 ml. The direct and indirect Coombs' tests were positive, as were tests for "cold and warm agglutinins." The bone marrow was described as showing "erythroid hypoplasia with myeloid hyperplasia and mild eosinophilia." Reticulocyte counts were consistently negative. Despite considerable difficulty in typing and crossmatching, the patient received 10 units of blood over several days, with elevation of his hemoglobin to 7 Gm. He was treated during this hospitalization with hydrocortisone, Achromycin, Colystin®, folic acid, and Amphojel®.

## Physical Examination

Upon admission to University Hospital the patient was jaundiced, semicomatose, and moribund. His temperature was 100°F, blood pressure 120/60, pulse rate 130, and respiratory rate, 44 per minute. The mucous membranes were dry. The sclerae were icteric. The chest showed bilateral basilar inspiratory rales, more pronounced on the right side, and some dullness to percussion at the right lung base. Cardiac auscultation confirmed the tachycardia, with frequent extrasystoles, and a ventricular gallop sound at the apex. The liver was palpable 4 cm. below the right costal margin, but the spleen could not be felt. Heal-

## Presented by

- Bertha Bouroncle, M.D., Columbus, and
  - Colin R. Macpherson, M.D., Columbus.
- Edited by Dr. Macpherson.

ing thrombophlebitis was noted in the right leg. The neurological examination was unremarkable except for severe depression of the sensorium.

## Laboratory Data

The white blood cell count was 52,900 with 61 per cent neutrophils, 4 per cent eosinophils, 16 per cent lymphocytes, 9 per cent monocytes, and 10 per cent plasma cells. The hemoglobin was 5.4 Gm. on admission but dropped to 3.3 Gm. the following morning. Very marked auto-agglutination, very numerous spherocytes and microcytes were noted on the peripheral blood smear. The blood samples drawn for laboratory tests showed a considerable tendency to clot within the tubes in spite of the use of anticoagulants. The coagulation time by the Lee and White method, however, was 8 min. 52 sec. (within normal limits in this laboratory). Bone marrow examination showed depression of both red cell and white cell elements and 15 per cent plasma cells which were thought, however, to be normal morphologically. The urine was unremarkable except for 50 mg. of protein per 100 ml.

## Hospital Course

Because of difficulty in crossmatching the patient's blood, no blood could be made immediately available for him. The patient was in extremis the following morning with rapid and shallow respirations, clinical shock, and tachycardia. A unit of uncrossmatched blood was begun with pressure infusion, but the patient continued to deteriorate and was pronounced dead 16 hours after admission.

## CLINICAL DISCUSSION

DR. BOURONCLE: I will say that when I read the protocol I thought this was a coroner's case. We



have very little history from the referring doctor, very little in the way of physical examination, and very few laboratory tests. The first symptoms were of thrombophlebitis of the right leg which had cleared a few weeks later, so this was not really of any great significance. Then he had an acute episode of epigastric pain, diarrhea, fever, chills with a temperature of 103°. This, as you know, can be produced by many things. But one thing that was given to us is that the hemoglobin was 9 grams and four days later went down to 3.3 grams. We therefore have to think of what can produce a decrease in hemoglobin of that degree. There are only two things: one is acute massive bleeding and the other is an acute hemolytic anemia, or hemolytic crisis. He did not have any black stools and when he was in the hospital his stools were negative for occult blood. I would assume that there was no massive bleeding.

### Hemolysis

The most likely diagnosis of this abrupt anemia is hemolysis. Now how can we support this diagnosis? One thing that I think is very significant is the observation that I imagine was made by the medical student who was drawing blood from this patient on admission—that the patient's blood was clotting in the syringe. This happened to me early in the game and I learned that in these cases it wasn't really clotting, but the red cells are clumped and agglutinated. When this happens you have to think of two things; one is cryoglobulins and the other, cold agglutinins. As to cryoglobulins we have no information, but we do know that he had cold agglutinins because this was confirmed by the laboratory.

### Cold Agglutinins

Cold agglutinins are very interesting and as you know they can accompany idiopathic hemolytic anemia. Cold agglutinins are also sometimes associated with atypical viral pneumonia. This man had leukocytosis with neutrophilia and rales in the bases of both lungs, so I assume that he might have had complicating bronchopneumonia rather than a viral infection. Unfortunately there is no chest x-ray for us to see. Cold agglutinins have been described also in cirrhosis of the liver, but in this patient we do not have what you would expect in hepatic coma. He was jaundiced, but he was jaundiced solely because of hemolysis. Then cold agglutinins have been described in some cases of malignancy, and he may have had a hidden malignant tumor, but cold agglutinins and cryoglobulins have also been described in multiple myeloma, which is one of the two diagnoses that we will go into in more detail.

### And Warm Panagglutinins

This patient had more than cold agglutinins; he also had warm panagglutinins. This again is compatible with idiopathic hemolytic anemia, but atypical pneumonia and many of the other differential diag-

noses are not usually accompanied by panagglutinins. So when you have found warm panagglutinins you narrow your diagnosis. Again, there are other causes for hemolytic anemia. We have to consider medications, toxins, all medications. This patient apparently was not exposed to any. Patients that have a congenital defect of the red cells and have received drugs such as pamaquine will show hemolytic anemia and sometimes a hemolytic crisis. I have never seen one with the intensity of this man's, but it is possible. We also have to consider a congenital hemolytic anemia. This man had spherocytes in the peripheral blood. Spherocytes are always present in a congenital spherocytic anemia but they are seen also in some acquired hemolytic anemias, and mainly in real acute hemolysis. So spherocytosis is not pathognomonic of congenital spherocytic anemia and in this patient, who was 49 years old and had never had any symptoms of jaundice or anemia, I would say that this is most probably an acquired hemolytic anemia.

### Thrombotic Thrombocytopenic Purpura

Another condition in which the patient comes in stuporous, with central nervous system involvement, with thrombophlebitis or other evidence of thrombosis, and hemolytic anemia as marked as this, is thrombotic thrombocytopenic purpura. However, the platelets in this patient were estimated as normal and at no time did he have any evidence of bleeding. For this reason we can probably rule out this diagnosis, but this triad of hemolytic anemia, neurologic findings, and thrombocytopenia should make you think of thrombotic thrombocytopenic purpura.

So now we are down to hemolytic anemia—the so-called cold agglutinin type. Some cases have been described in which this was the only problem: the patient had a primary hemolytic anemia with cold agglutinins. I don't believe we are dealing with a primary cold agglutinin because as we go down we find a few more tips from the laboratory to make us think that there is an underlying disease, that this is not a primary hemolytic anemia. If we look for an underlying cause for this hemolysis, malignancy is the main thing. We have seen hemolytic anemias accompany malignant tumors and if you remove the primary tumor the hemolytic anemia will be corrected. I don't know if we can completely rule out this possibility.

However, you also have hemolytic anemias in other kinds of diseases. For example, hemolytic anemia is the usual complication of chronic lymphatic leukemia. About 10 to 15 per cent of all patients with chronic lymphatic leukemia will develop a frank hemolytic anemia sometime. All chronic lymphatic leukemias, if you look for hemolysis by doing tests such as the red cell survival, will have some degree of hemolysis, but frank hemolysis is seen in 10 to 15 per cent of the cases. However, the bone marrow findings and the peripheral blood in this patient do

not help in diagnosing chronic lymphatic leukemia. We see this same problem in other lymphomas—Hodgkin's disease, lymphosarcoma, and reticulum cell sarcoma.

This patient had 10 per cent plasma cells in the peripheral blood and had 15 per cent plasma cells in the bone marrow. What is the significance of the plasma cells? It is very unusual to find them in the peripheral blood but it is not unusual to find them in the bone marrow. Every time you find plasma cells in the bone marrow you have to rule out the possibility of multiple myeloma, but besides that you have many other illnesses, like amyloidosis or macroglobulinemia, in which you are going to find plasma cells.

### Myeloma?

How do you make a diagnosis of myeloma? We say clinically that to make a diagnosis of myeloma you should have two of four features present. The first is the presence of plasma cells in the bone marrow. In multiple myeloma the plasma cells can have any morphology from normal plasma cells to most bizarre cells. They have even been confused with monocytic leukemia by good investigators. Secondly, on electrophoresis you may find the M-protein either in the serum or urine. I would say that in about 65 to 70 per cent of the cases of multiple myeloma you find a big homogeneous globulin peak mostly located in the gamma fraction. We don't have any information about the electrophoresis on this man, so we cannot use that. The third thing is osteolytic lesions, or some type of bone lesions, in any of the bones of the body. This patient did not have any x-rays. The fourth finding is other types of abnormal proteins, like cryoglobulins or Bence Jones protein. So if you have two of these four you can make for sure the diagnosis of multiple myeloma. In this patient we have only one of the four available, but I would still say that we cannot rule out the diagnosis of multiple myeloma. This patient had proteinuria but I imagine this was only a single specimen and all we can say is that he had proteinuria.

I am afraid we don't have anything else to go on to reach a diagnosis. If we have to make a diagnosis I would say that most likely he had a hemolytic anemia, a very acute crisis of hemolytic anemia, probably secondary to an underlying disease. If I had to make one diagnosis I would choose multiple myeloma. My second choice would be a hidden malignancy, and it is not impossible that there are two malignancies. I believe that this man probably also had a secondary infection, probably bronchopneumonia, which could explain the marked degree of leukocytosis with neutrophilia in the peripheral blood. I think this is all I can do with the information I have.

### Spherocytosis?

DR. DOAN: We have seen patients at 49 years of age who had no previous acute crises that did have

underlying congenital hemolytic icterus. Can you account for this microcytic spherocytosis as an acquired combination?

DR. BOURONCLE: I will agree that we see spherocytosis and microcytic or spherocytic anemia in all cases of congenital hemolytic anemia, but we have seen them also in acquired types of hemolytic anemia.

DR. DOAN: How do you explain the hypoplasia of erythroid elements in the bone marrow?

DR. BOURONCLE: The hypoplasia of the bone marrow can be explained by two things: In some cases of acute hemolytic anemia you have the megaloblastic type of cells; this is what we call the aplastic crisis of hemolytic anemia. The second is because the bone marrow was really occupied by another type of cell. This is also the way of explaining the lack of reticulocytosis.

DR. DOAN: Correct. That is what I thought too. The bone marrow probably was fairly well packed with plasma cells even though only 15 per cent were counted. Notoriously, differential counts may be excellent for the area that you count but they don't give the overall impression.

DR. GWINUP: I can't explain the severe depression of sensorium unless the patient had thrombotic thrombocytopenic purpura, and also the apparent cardiovascular problem with the development of a ventricular gallop.

DR. BOURONCLE: The cardiovascular problem I think is related to the anemia. You see everything in a patient who goes down rapidly to 2 to 3 Gm. of hemoglobin.

MEDICAL STUDENT: Couldn't this tendency of the blood to clot be the result of hypercalcemia?

DR. GWINUP: I have seen some awfully high calciums, but I have never seen it. I don't believe you ever get coagulation problems on the basis of low or high calcium.

### CLINICAL DIAGNOSIS

1. Hemolytic anemia in crisis, probably secondary to underlying disease.
2. Multiple myeloma.
3. Bronchopneumonia.

### PATHOLOGIC DIAGNOSIS

1. Dysproteinemia.

### DISCUSSION OF PATHOLOGY

DR. MACPHERSON: As you may have gathered, this is a slightly complicated case. There were a number of different findings but the main problem was to try to squeeze them into one diagnostic category. First of all, the patient did not show any evidence of petechial hemorrhages. The plasma which was removed at the time of autopsy showed



very obvious hemolysis. Another significant finding: In the abdomen there were matted masses of lymph nodes surrounding the aorta, and also some panniculitis was seen. The lymph nodes in the mediastinum were prominent; there were palpable lymph nodes in the axillae and in the inguinal region but these were not very impressive. There was very marked abnormality of the spleen; it weighed 550 Gm. and showed multiple infarcts rather peculiarly distributed along the surface or just under the capsule. The liver was markedly enlarged, nearly 3000 Gm., but it was also remarkably normal; it really showed nothing other than congestion.

Histologically, there is a lesion in the wall of the myocardium which is actually a deposit of some fibrinoid material in relation to blood vessels. There were a few of these vessels in the myocardium but not sufficient to account for the patient's cardiac symptoms, which I think were much more likely related to his anemia. The lung showed only congestion and edema. There were two peptic ulcers in the pyloric region, and the striking thing here was the necrotic mucous membrane. They were not deep ulcers. In the submucosa there were vascular lesions, also seen elsewhere.

In the liver the portal tracts appeared to be rather larger and to have more cells than is normal. There was a blurring and merging of the connective tissue fibers or the intercellular matrix in the portal triads. In some cases this could be an extension from a vessel into the connective tissue. In other cases it looked more like an infiltration of some abnormal protein. The second thing you have is that these cells are predominantly plasma cells. They were bizarre plasma cells in many cases, and the area included a surprising number of eosinophils. This type of thing was seen elsewhere in the body also, for example, in the pancreas.

The interesting thing about the spleen was that there were no detectable thrombi occluding vessels to account for the amount of infarction that we saw grossly. Vessels quite a distance from the infarction showed striking infiltration of some kind of proteinaceous material. One of the nodes taken from the lower part of the aorta showed cellular infiltration extending out through the capsule into the fat beyond the node. Again there was this rather strange cellular pattern — plasma cells showing varying degrees of abnormality and occasional eosinophils. This was quite variable; in some parts of the node there were a lot of eosinophils and in other areas there were relatively few. So this adds another dimension: there was an abnormality of the lymph nodes, with partial destruction of the normal architecture and infiltration through the capsule of the node, which showed a superficial resemblance to Hodgkin's granuloma.

The kidney showed a very striking abnormality. The afferent and efferent arterioles showed an acute

fibrinoid type of change. This did not extend much into the glomerular tuft, which showed only very marked congestion. This was a very widespread change in the kidney; it involved about half the glomeruli I examined. The bone marrow showed remarkably few cells of the erythroid series at any stage of development. Megakaryocytes were numerous all over the bone marrow. One could see quite a number of plasma cells, showing varying degrees of abnormality, but they were not infiltrating and replacing the marrow. There were moderate numbers of myeloid cells but very few cells of the erythroid series.

This patient's lesions in summary were; hepatosplenomegaly, lymphadenopathy, hemolytic anemia with positive direct Coombs' test, cold agglutinins of very marked degree, red cell aplasia, a vasculitis which was most striking in the kidney, plasma cells and eosinophils infiltrating the tissues (primarily in liver and lymph nodes). When you try to tie these things together you think either of one of the collagen diseases or of a hypersensitivity state due to drugs or something of the sort. There are difficulties in the way of either one of these diagnoses. First of all, we don't know that he had any drug. This isn't an insuperable difficulty but unfortunately I can't think of any drug that would produce all of these things plus a hemolytic anemia with positive direct Coombs. None of the collagen diseases fits, either.

#### Franklin's Disease?

There is one large question mark. One critical piece of information is the electrophoretic pattern of this patient's serum. It says in the patient's chart that electrophoresis was done but no report can be found. One possible diagnosis that was considered was Franklin's disease,<sup>1</sup> also known as "H, gamma 2." This typifies the general field in which this patient's anomaly belongs, I think. In this disease there is an abnormal production of part of a gamma 2 globulin, the "heavy" fraction. What happens is that the one type of cell in the body produces this fraction of  $\alpha$ -globulin to excess with the result that the production of normal  $\alpha$ -globulin is seriously inhibited. Franklin described a fluctuating lymphadenopathy with eosinophils and plasma cells in the lymph nodes; splenomegaly; hepatomegaly (in two of the three patients); edema of the palate (two of three patients); pyrexia, which we saw in this case; anemia, which we certainly have; leukopenia, which we certainly do *not* have; and there were immature lymphocytes and/or plasma cells circulating in the peripheral blood.

#### A Dysproteinemia

The concept at the present time is that these dysproteinemias are related to malignancy of one of the strains of the plasma cells which normally produce the  $\alpha$ -globulins. One of these strains takes over

and produces in an undisciplined fashion masses of a particular abnormal protein. If it happens to be the heavy fraction of a gamma 2 globulin, you refer to this as an "H, gamma 2." The important points are, first of all, that this is basically a malignancy, a malignancy of a very restricted functional cell type. Secondly, it is important to realize that this type of abnormality can lead to all kinds of widely separate lesions which appear at first to have no relationship to the underlying neoplasia. So, although lacking the essential information for a definitive diagnosis, I would suggest that this patient probably had a dysproteinemia, which would be a first cousin to Waldenström's macroglobulinemia, a first cousin to multiple myeloma, and also possibly to Franklin's disease and the other syndromes that have been described in this general area.

DR. DOAN: Was there any other disease in the kidneys apart from the glomeruli?

DR. MACPHERSON: No, these vascular lesions in the base of the glomeruli and congestion of the tufts themselves were the only lesions.

DR. DOAN: That would be unlike the kidney of an ordinary plasma cell myeloma?

DR. MACPHERSON: No, this is certainly not like a myeloma kidney.

DR. BOURONCLE: I would just like to close by saying that I think dysproteinemia is the diagnosis. This term has been created because this case doesn't exactly fit multiple myeloma, but it is very close to multiple myeloma and was described as such for many years. In that group you also have amyloidosis, you have macroglobulinemia, Franklin's disease, and many other diseases.

#### Reference

1. Osserman, E. F., and Takatsuki, K.: Plasma Cell Myeloma: Gamma Globulin Synthesis and Structure. A Review of Biochemical and Clinical Data, with the Description of a Newly-Recognized and Related Syndrome, "H<sub>2</sub>-Chain (Franklin's) Disease." *Medicine*, 42:337-384, 1965.

**N**ONSPECIFIC ANTI-INFLAMMATORY AGENTS. — Eight synthetically modified corticosteroid compounds are available commercially. Each of them exhibits qualitative differences in one or several physiologic actions, each has certain advantages and disadvantages in therapy, and each shares the major deterrent features of corticosteroids. Prednisone, prednisolone, methylprednisolone, fluprednisolone and paramethasone have similar therapeutic indices, and there is little choice between them for the usual rheumatoid patient requiring steroid therapy. Conversely, the therapeutic indices of dexamethasone, betamethasone and triamcinolone are lower than that of prednisolone; they are less desirable for routine use and should be reserved for specially selected cases.

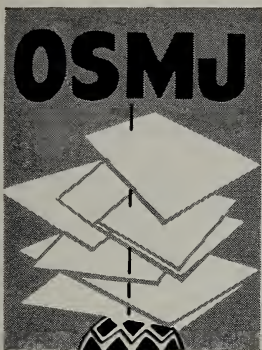
Salicylates are preferred to adrenocortical steroids in the treatment of the ordinary patient with acute rheumatic fever. Steroid therapy should be reserved for resistant cases and for those with significant carditis. Salicylates are mainstays for pain relief in rheumatoid arthritis, but with the analgesic doses usually employed their anti-inflammatory action is slight.

Phenylbutazone is a highly useful anti-inflammatory agent, especially in management of acute gouty arthritis and ankylosing (rheumatoid) spondylitis; its metabolite, oxyphenylbutazone, does not exhibit clear-cut advantages.

Colchicine specifically suppresses acute gouty arthritis. Its analogues, desacetylcolchicine and desacetylthiocolchicine, produce fewer unpleasant gastrointestinal symptoms, but may promote agranulocytosis and alopecia.

A number of indole preparations with anti-inflammatory activity have been tested clinically. One of them, indomethacin, has received extensive therapeutic trial; with dosages that can be tolerated the drug is fairly effective in the symptomatic control of ankylosing (rheumatoid) spondylitis but it is of questionable value in peripheral rheumatoid arthritis. — Edward W. Boland, M.D., Los Angeles, *California Medicine*, 100:145-155 (March) 1964.





# NEWS AND *Organization Section*

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## Proceedings of The Council . . .

### Report of Actions Taken at December 12-13 Meeting In Columbus, Including Approval of Budget for 1965

A REGULAR MEETING of The Council of the Ohio State Medical Association was held on December 12 and 13, 1964, at the OSMA Headquarters Office, Columbus. All members of The Council, except Dr. Philip B. Hardyman, treasurer, were present. Others attending were: Dr. John H. Budd, Cleveland, AMA delegate and chairman of the Ohio delegation; Mr. Wayne E. Stichter, Toledo, legal counsel; Dr. Perry R. Ayres, Columbus, Editor of *The Journal*; and Messrs. Saville, Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff. The following guests (by invitation) attended the meeting on Sunday: Dr. Anthony Ruppertsberg and Dr. Thomas Rardin, Columbus; Mrs. John D. Dickie, Toledo, President and Mrs. Herbert Van Epps, Dover, President-Elect of the Woman's Auxiliary to the Ohio State Medical Association.

#### Announcements by President Tschantz

Dr. Tschantz extended felicitations to Mr. Saville and expressed the best wishes of the Officers and Councilors for his continued recovery from an illness which occurred to him on November 12.

He also extended, on behalf of The Council, greetings to Dr. Philip B. Hardyman, Treasurer of the Association, who was unable to attend this session of The Council.

Dr. Tschantz announced that the next two or three months probably will be as important as any period in the history of medical organization. He stressed the importance of good communications and a united front with all individual medical societies and physicians speaking as one voice.

Dr. Tschantz announced a meeting with the officials of the American Medical Association on December 13, attended by Drs. Tschantz and Crawford and

by Mr. Edgar of the OSMA staff. Another meeting on January 9 and 10, 1965, will be held with the same representatives attending.

#### Minutes Approved

The minutes of the meeting of The Council held on September 20-21, 1964, were approved by official action.

#### Membership Statistics

The following membership statistics were announced by Mr. Page: OSMA membership as of December 11, 1964, 9,921, compared to a total membership at the end of 1963 of 9,743. The report stated that of the 9,921 OSMA members, 8,913 were affiliated with the AMA.

#### Membership Questions

The question of the eligibility of dentists as honorary members of the Richland County Medical Society was raised in a communication from a member of that society. The Council advised that the by-laws of the Richland County Medical Society clearly state that dentists are eligible in this membership category.

The status of licensed non-citizen physicians in practice in Ohio was discussed. The question arose as to how many non-citizens who file a declaration of intent actually achieve citizenship. No action was taken.

Mr. Stichter discussed the wording of an amendment to the Constitution and By-Laws, proposed at the 1964 House of Delegates session and permitting members to request OSMA dues waiver after their 70th birthday.

#### Financial Report

The Council, in executive session, then considered the report of the Committee on Auditing and Ap-

propriations. The report of the committee, including the following budget for 1965, was approved by official action:

### BUDGET FOR 1965

The Ohio State Medical Journal .....	\$ 47,920.00
Consultant (GHS) .....	14,000.00
Executive Secretary (Acting), Salary .....	17,000.00
Executive Secretary (Acting), Expense .....	2,500.00
Administrative Assistant, Salary (H. E. G.) ..	9,500.00
Administrative Assistant, Expense (H. E. G.) ..	2,000.00
Administrative Assistant, Salary (W. M. T.) ..	8,600.00
Administrative Assistant, Expense (W. M. T.) ..	2,000.00
Stenographic and Clerical Salaries .....	58,220.00
President, Expense; and Honorarium (\$2,000.00) .....	6,500.00
President-Elect, Expense; and Honorarium (\$1,000.00) .....	3,500.00
Council, Expense .....	6,500.00
American Medical Association Delegates and Alternates .....	18,000.00
<b>Dept. of Public Relations (\$26,500)</b>	
Acting Director and Acting Assistant Ex- ecutive Secretary, Salary .....	15,500.00
Acting Director, Expense .....	2,500.00
Exhibits and Newspaper Publicity .....	500.00
Literature .....	500.00
Postage .....	3,000.00
Supplies .....	500.00
Miscellaneous Activities .....	4,000.00
<b>Committees:</b>	
Education .....	500.00
Judicial and Professional Relations .....	600.00
Public Relations and Economics .....	400.00
Scientific Work .....	800.00
Auditing and Appropriations; Bookkeeping ..	1,270.00
Cancer .....	150.00
Care of the Aged .....	600.00
Disaster Medical Care .....	700.00
Eye Care .....	300.00
Hospital Relations .....	500.00
Laboratory Medicine .....	700.00
Maternal Health .....	1,500.00
Medicine and Religion .....	350.00
Mental Health .....	900.00
Occupational Health .....	300.00
Poison Control .....	150.00
Radiation .....	100.00
Rural Health .....	1,900.00
School Health .....	1,500.00
Traffic Safety .....	200.00
Workmen's Compensation .....	500.00
Annual Meeting .....	29,500.00
Conference of County Society Officers .....	1,900.00
Councilor District Conferences .....	4,500.00
Emergency and Equipment Fund .....	5,500.00
Employees' Retirement Fund .....	9,840.00
Insurance, Bonding and Social Security .....	8,620.00
Lectures for Senior Medical Students .....	3,700.00
Legal Expense .....	10,000.00
Library .....	300.00
OSMAgram .....	6,000.00
Postage .....	2,800.00
Professional Relations Activities .....	6,500.00
Rent and Utilities .....	13,300.00
Rural Medical Scholarships .....	3,000.00
Stationery and Supplies .....	5,000.00
Telephone and Telegraph .....	5,000.00
Woman's Auxiliary Contribution .....	1,500.00
<b>Total .....</b>	<b>\$353,620.00</b>

### Mr. George H. Saville

During the executive session The Council voted that, as of December 12, 1964, Executive Secretary George H. Saville, at his own request, be appointed as

"a consultant upon request." The Council specified that Mr. Saville be retained through August 1965 and be paid at his existing salary rate through August 1965. It was authorized that if he chooses, he may draw this total of \$14,000 over the entire year of 1965. It is understood that he may not accept any other employment without the knowledge and consent of The Council of the Ohio State Medical Association during the pay period which he chooses.

### Staff Promotions

Also effective December 12, 1964, Hart F. Page, the Assistant Executive Secretary and Director of Public Relations, was advanced to Acting Executive Secretary. Mr. Charles W. Edgar, Executive Assistant, was advanced to Acting Director of Public Relations and Acting Assistant Executive Secretary. It was agreed that the word "acting" affiliated with the titles of Mr. Page and Mr. Edgar may be removed at the discretion of The Council within a period not to exceed one year.

### Signature Resolution

By official action on December 13, 1964, The Council of the Ohio State Medical Association adopted a resolution, effective January 1, 1965, authorizing the President and Acting Executive Secretary Hart F. Page to sign checks against the funds of the Association deposited in the Savings Account at the Ohio National Bank, Columbus, (only one signature required); and to sign checks against funds of the Association deposited in the Executive Secretary's A. M. A. Dues Account at the Huntington National Bank, Columbus.

In a subsequent official action, effective January 1, 1965, The Council authorized the following to sign checks against The Ohio State Medical Journal Account in the Ohio National Bank (only one signature to be required); Florence W. Okert, Assistant Business Manager, and Hart F. Page, Acting Business Manager.

### Proposed Increase in OSMA Dues

The Auditing and Appropriations Committee presented the following resolution, which was adopted by The Council without a dissenting vote:

WHEREAS, At the 1965 Annual Meeting of the Ohio State Medical Association the delegates will act on a resolution to waive dues for members over 70 years of age on their request and such an amendment, if presented, will result in a marked decrease in revenue to the Association; and

WHEREAS, The Association is faced with the situation in which expenses are rising but income is not increasing, making it necessary to include income from previous years to bring the 1965 budget into balance; and

WHEREAS, Ohio is currently one of three



state medical associations with the lowest dues in the country; and

WHEREAS, Medicine faces its time of greatest challenge, and has found it necessary to expand existing programs as well as to initiate additional activities;

THEREFORE, BE IT RESOLVED, That The Council of the Ohio State Medical Association sponsor at the May, 1965 Annual Meeting in the House of Delegates a resolution to increase the annual Ohio State Medical Association dues to \$50.00, effective January 1, 1966.

#### **Report on AMA Meeting in Miami**

Dr. Budd reported as chairman of the Ohio delegates to the American Medical Association on the Miami meeting of the AMA held on November 29 - December 2. Dr. Budd announced that President Ward, in his address to the House of Delegates, announced continued opposition to the "King-Anderson" type of legislation.

Teletypewriter exchange service between the American Medical Association and the state societies was approved at the meeting.

The delegates voted that there would be no increase in American Medical Association dues at the present time.

Dr. Budd reported that a resolution sponsored by the Ohio delegation regarding the seating of alternate delegates was approved.

The Council approved Dr. Budd's report and approved the minutes of the meetings of the Ohio delegates and alternates held on November 29 and on December 2.

The Council voted to submit, on behalf of the Ohio State Medical Association, the nomination of Dr. P. John Robeck, Cleveland, for membership on the Council on Medical Education of the American Medical Association. The Council authorized Dr. Budd, as chairman of the delegation, to send a formal request that Dr. Robeck be nominated.

#### **Reports by Councilors**

During the reports of Councilors, Dr. Howard said that he regularly reports to the counties in his district with regard to the actions of the OSMA Council and that delegates to the OSMA are not always represented at these meetings. He announced that some counties are now inviting OSMA delegates to their council meetings. He suggested that it would be helpful if the OSMA staff would furnish a summary of Council actions to be forwarded by each Councilor to the delegates in his area.

#### **Stark County Resolution**

A telegram from the Stark County Medical Society, notifying The Council of a resolution adopted by the society on December 10, was received and read to The Council. The essence of the resolution is as follows:

"Since the Stark County Medical Society has

always believed in medical care for everyone who needs it regardless of ability to pay whether over or under age of sixty-five.

"We therefore reaffirm this belief and add that we request this financial assistance for these people come first from their families, voluntary charitable organizations, municipalities, counties and state before considering it necessary to seek federal aid.

"We believe that this type of aid is available in Ohio to give those who need it complete care rather than the partial care for all those over sixty-five whether they need it or not."

#### **1965 Annual Meeting**

Mr. Page announced that the Ohio State Surgical Association has decided to hold its meeting in connection with the meeting of the Ohio State Medical Association on Monday, May 10.

Other details concerning the 1965 Annual Meeting were reported.

#### **1968 Annual Meeting**

On motion duly made, seconded and carried, The Council voted to release facilities in Cleveland which had been held for the 1968 meeting, inasmuch as the 1968 meeting has been scheduled for Cincinnati, May 12-17.

#### **OMI Nominating Committee To Be Appointed**

By official action, The Council authorized President Tschantz to appoint a nominating committee to select nominees for the Ohio Medical Indemnity Board of Directors, such nominees to be voted on at the annual OMI stockholders meeting next April.

#### **OMI Liaison Committee Report**

Dr. Fulton reported for the OMI Liaison Committee. He said the OMI Comprehensive Coverage has now been approved in 65 of the 88 county medical societies. He told The Council that the financial picture of OMI is considerably improved over last year. He announced that on December 3 the Columbus Surgical Society disapproved the OMI Comprehensive Coverage.

#### **1965 County Society Officers Conference**

Mr. Edgar presented the tentative program for the 1965 County Society Officers' Conference to be held February 28. The Council accepted the program and stated that any changes may be made at the discretion of the President.

#### **Report on Fall District Conferences**

Mr. Page submitted for The Council's information a report on the attendance at the 1964 Fall Councilor District Conferences.

#### **Report on Cardiovascular Conference**

Dr. Ayres, as the representative for the Ohio State Medical Association, attended the National Cardiovascular Conference in Washington, D. C. on November 22-24. He said the purpose of the conference was to evaluate the present status of cardiovascular

diseases, to discuss the unmet needs in research, education, and community services, and to predict the direction into which this field will move. He said that Ohio has been asked to have a similar conference guided by a committee including Dr. George Morrice, Jr., Columbus, representing the Ohio State Heart Association, Dr. John Robinson of the Ohio Department of Health and Dr. Ayres. All three attended the national conference representing their agencies. The report was approved by official action.

### Journal Readership Problems

Readership problems of state medical journals and obtaining pharmaceutical advertising in competition with "throw-away" magazines were reviewed by Dr. Ayres, Editor of *The Journal*. He also discussed this from the standpoint of his position as chairman of the Special Committee on Policy of the State Medical Journal Advertising Bureau and a member of the Bureau's Board of Directors.

### OSMJ Survey

Dr. Ayres announced an *Ohio State Medical Journal* readership survey to be conducted in the January, 1965, issue. He urged the Councilors to bring this survey to the attention of the members of the Association. The report was approved.

The Council also approved reports by Dr. Ayres and by Mr. Moore on the State Medical Journal Conference in Baltimore, Maryland, on October 3 and 4, 1964.

### Legislation

The Council discussed proposed legislation which would modify the Ohio law concerning the State Hospital Advisory Council in connection with the administration of the Hill-Burton Act. Section 604 (a) of Title VI of Public Law 88-443 of August 18, 1964, passed by Congress makes certain modifications mandatory, especially with regard to the makeup of the State Hospital Advisory Council. The Council voted not to oppose the state legislation if properly drafted.

The attention of members of The Council was directed to a report of the Legislative Service Commission Study of Hospital Service Associations (Blue Cross) as published on page 1149 of the December issue of *The Journal*.

The Council voted to support proposed legislation to amend Sections 4513.11 and 4513.17 of the Revised Code to require an identification emblem for certain slow moving vehicles providing the legislation is properly drafted.

The Council voted approval and support of a proposed bill to prohibit advertising by name of prescription legend drugs.

The Council discussed proposed legislation affecting professional licensing boards. It was voted not to oppose these bills if they are properly drafted.

An official request from the Ohio Society of Pathologists, proposing state legislation with regard

to laboratories, was referred to the Committee on Laboratory Medicine of the Ohio State Medical Association for study.

### Committee Reports

**Mental Health** — Mr. Traphagan reported for the Committee on Mental Hygiene. The name of this committee was officially changed to the Committee on Mental Health. The report of the committee was approved with the following exceptions:

On motion duly made, seconded and carried, The Council voted that a Subcommittee on Addiction be established in the Committee on Mental Health and the members of such subcommittee to be appointed from the committee by the chairman. The Council also authorized the committee to explore the possibilities of a self-supporting postgraduate day in the field of mental health for physicians, to be held in cooperation with the Ohio Psychiatric Association, the Ohio Academy of General Practice and other interested medical groups.

**Disaster Medical Care** — The report of the Committee on Disaster Medical Care, presented by Mr. Traphagan, was approved as presented.

**Public Relations and Economics** — The report of the Committee on Public Relations and Economics was presented by Mr. Page. Such report concerned the educational activities with regard to a law requiring that applicants for marriage licenses be examined to determine the absence of syphilis in a contagious state before a marriage license can be issued. The Council approved the educational program outlined by the committee, with the exception of that part which would have involved the supplying of pamphlets to marriage license applicants through the offices of the clerks of probate courts in Ohio.

The report of the joint meeting of the OSMA Committee on Public Relations and Economics with the Interprofessional Relations Committee of the Ohio State Pharmaceutical Association was approved as presented.

**Maternal Health** — Dr. Ruppertsberg presented the report of the Committee on Maternal Health. He directed the attention of The Council to an article in the July 27, 1964, issue of the *Journal of the American Medical Association* entitled "How Is a Nation's Health Level Measured?" This article, he said, discusses the implication of infant mortality rates and was presented by the staff of the Department of Community Health and Health Education of the AMA in collaboration with the Committee on Maternal and Child Care and its special consultants. The conclusion of this article is that general, maternal, and infant mortality rates, and the estimated life expectancy are not reliable measures of health levels among nations. These statistics are products of many variable factors and are essentially crude measure-



ments; extreme caution should be used in drawing conclusions from them.

The Council voted to approve the minutes of the October 11, 1964, meeting of the Committee on Maternal Health, with the exception of the resolution concerning obstetric anesthesia on page 2. The Council took no action on this resolution.

**Hospital Relations**—Mr. Gillen submitted a progress report of the Committee on Hospital Relations. He indicated that a good response was being received from a survey through each county medical society of all hospitals in the state concerning the procedures currently used in billing for physicians' services in each of the six categories. Mr. Gillen announced that the committee would meet on January 17, 1965, to consider the replies. The Council accepted this report.

#### Licking County Amendments

Amendments to the Constitution and By-Laws of the Licking County Medical Society were considered. The Council approved the amendments but suggested that the form of the resolution to amend be modified.

#### Matters Referred to Committee On Hospital Relations

A communication from the Ohio State Nurses' Association regarding the role of the nurse in cardiopulmonary resuscitation and proposed guides concerning this procedure were referred to the Committee on Hospital Relations for study.

Mr. Edgar presented a report on the proposed central health information service, grants for which have been made available to the various states from the U. S. Public Health Service. On motion duly made, seconded and carried, The Council directed the Committee on Hospital Relations to study this matter.

#### V. A. Hometown Care Program

A communication from the Veterans Administration in regard to changes in the Administration's Hometown Care Program for Veterans was considered by The Council. On motion duly made, seconded and carried, The Council voted to advise the Veterans Administration that it cannot enter into an agreement with the Veterans Administration which would bind individual physicians. The Council expressed its willingness to work with the Veterans Administration in developing a fair and reasonable fee schedule.

#### Cleveland Invitation for AMA Meeting

A communication from the Cleveland Academy of Medicine, asking Council's support in bringing a clinical convention of the AMA to the City of Cleveland, was considered. On motion duly made, seconded and carried, The Council voted to join the invitation of the Academy of Medicine of Cleveland and Cuyahoga County in this regard and directed the Executive Secretary to so notify the American Medical Association.

#### Report of Woman's Auxiliary

Mrs. John D. Dickie, Toledo, President, and Mrs. Herbert Van Epps, Dover, President-Elect of the Woman's Auxiliary, addressed The Council concerning problems, activities and goals of the Woman's Auxiliary to the Ohio State Medical Association. Among the expressed needs of the Auxiliary is a sufficient budget to meet the growing accomplishments and greater undertakings of the organization. On motion duly made, seconded and carried, The Council congratulated Mrs. Dickie and Mrs. Van Epps on the competency of their leadership and the enthusiasm of all the officers in the work of the organization. It offered the support of all Councilors in helping to promote an even greater interest in the Auxiliary in its undertakings.

The Council suggested that the Auxiliary go ahead with procedures to increase the dues of the organization, with the consultation of the advisory committee. The Council expressed itself as being opposed to the concept of "team membership" which would involve the payment of Auxiliary dues along with the physician's dues to his county society, the OSMA and the AMA.

#### Proposed American Board Of Family Practice

Dr. Thomas A. Rardin appeared before The Council in regard to a proposal for an American Board of Family Practice. After considerable discussion, it was voted to hold this item of business for further study.

#### Request for OSMA Mailing List

A request from the Central Hospital Service for a mailing list of OSMA members was considered. The Council reaffirmed its existing policy that the release of the mailing list be restricted to scientific societies by authorization of The Council.

#### Ohio Society of Medical Assistants

Dr. Meredith reported for the Advisory Committee to the Ohio Society of Medical Assistants. He announced that it has been proposed that the Advisory Committee be enlarged by adding three physicians chosen by the House of Delegates of the Ohio Society of Medical Assistants at the annual meeting of that organization. The Council voted to support a recommendation of the Advisory Committee that the present structure not be changed.

#### Blood Insurance Programs

With regard to a request for Council expression on the problem of blood insurance programs, The Council approved the policy of the American Medical Association, in principle, until a further study of this matter has been undertaken by the Committee on Hospital Relations.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: HART F. PAGE

*Executive Secretary, Acting*

# What Is the Job of the Individual In a Mass Medical Emergency

**F**OLLOWING is continuation of the report of the Conference on Disaster Medical Care held in Columbus, October 18. Last month's part of the article contained summarizations of reports on what is being planned by the Division of Health Mobilization, lessons learned from the Toledo Airplane crash, experiences coming out of the Ohio Valley Flood, the Fitchville Nursing Home fire, disaster plan testing in the Cleveland area and the Alaskan earthquake disaster.

The entire summarization as well as concluding comments were written by Dr. Francis C. Jackson, chairman of the Committee on Disaster Medical Care of the American Medical Association, a participant in the conference.

\* \* \*

*(Concluded from January Issue)*

## **The Icecapades Disaster at Indianapolis Coliseum**

Carl D. Martz, M.D., clinical professor of orthopedic surgery, Indiana University School of Medicine, and chairman of the Indiana and Indianapolis Committees on Trauma of the American College of Surgeons, discussed the Indianapolis Coliseum Icecapades disaster.

Doctor Martz recounted the details of this disaster in some detail. The catastrophe was the worst in the history of the city and the state. It occurred on Halloween night, 1963, during the "shift time" at the hospitals and at the police departments.

There were two explosions. The second was followed by a large fire ball. The fifty foot crater was blown out beneath the seats. Four Hundred Thirty-Six people were injured or dead. There were 54 dead at the scene, eight died on arrival at the hospitals, and 19 died later of miscellaneous causes (cerebral contusions, hemothorax, ruptured viscus, and multiple amputations). One patient died of gas bacillus infection.

One hundred and sixty-five were admitted to the various hospitals, 209 were transported by ambulances. There were 26 head injuries, 13 burns, five chest injuries, and nine cervical spine fractures, and one abdominal crushing.

The extraction of the injured was carried out by the fire department. A cattle barn nearby was set up as

a sorting area fifty yards from the disaster site. Survivors were carried here on plywood sheets. Three rescue squads from hospitals and Red Cross reported. In the opinion of Doctor Martz, the usual first aid skills were not helpful to any of the injured.

Evacuation of the survivors was rapid. Only ten were left on the scene thirty minutes after the blast. Supplies were offered by the Eli Lilly Company. Transportation was by chartered busses, taxi cabs, and hospital ambulances. There was no shortage of vehicles.

A communication center was set up thirty minutes after the explosion by a local electrical contractor and remained as the primary message center for two hours. Later a Civil Defense unit was operational. However, there was ineffective and insufficient radio communications to the hospitals. Telephone improvisations were supplied by the telephone company.

An example of the load experienced by the telephone lines is suggested by the report that there were over 10,000 long distance calls still waiting connection by the early morning hours. Actually, by the time the communications were effective at the coliseum, all patients were either enroute to or admitted to the various hospitals.

Since there were a large group of Doctors in the Icecapade audience (including the President of the County Medical Society), there was no shortage of physicians at the disaster site. However, medical command was not established.

No attempt was made to inventory the various bed vacancies at the hospitals. The majority of patients were sent to the Saint Vincent's and Methodist Hospitals. Three other major hospitals were not utilized.

The principal problems were those of command, communications, and coordination. Hospitals were notified by the arrival of casualties, by television or radio, or by hospital personnel who happened to be listening to such commercial communications.

The coroner complained that there was an excessive loss of personal effects and that the clergy could have been more helpful.

Doctor Martz indicated that ten recommendations were made by the Indianapolis Committee on Trauma of the American College of Surgeons as follows:

1. That there be an understanding between the State Police, the Sheriff, and the Municipal Police



and Fire Departments relative to the assumption of command at disaster including the provision of communications, traffic control, and rescue activities.

2. That a medical command group be established to control all matters pertaining to the medical estimates of the situation, sorting and tagging of patients, priority of evacuation, emergency treatment, ambulance and hospital assignment, and overall medical regulation of casualties.

3. That the alerting and organization of doctors and the handling of casualties be under the direction of the medical division of Civil Defense and the office of the Coroner, in cooperation with the medical society and the local hospitals.

4. That the disaster or emergency committees of the local hospitals become an essential part of the civil defense medical organization.

5. That each and every participating doctor be given a place on the disaster roster and be made familiar with the functions expected of him at the time of disaster.

6. That doctors be provided with appropriate means of identification to identify them at the scene of the disaster.

7. That the private patient-personal physician relationship in hospitals be delayed until disaster control has been achieved and normal routine established.

8. That provision for secretarial help, police protection and lay assistance be provided to doctors to expedite their work.

9. That public relations be handled by the American Red Cross and enhanced by the services of the clergy in the matter of family contact.

10. That exercise and drills be carried out on a county-wide basis to ensure the proper functioning of all community organizations under disaster conditions.

### Office of the Sheriff

Major Alva R. Funk, executive officer to the sheriff of Marion County, Indianapolis, Indiana, reported that the first messages to the County Sheriff's office were inaccurate. The initial estimate of the dead was only ten. However, very promptly, all police in the county were recalled to active duty. Upon arriving at the disaster site, Major Funk called an immediate meeting to assess the situation and to provide organization. As a result of this impromptu meeting, which included the Sheriff, city police, fire chief, representatives, the Civil Defense Director, and the Coroner, a command post was set up. However, there was no physician assigned to the command post. Secondly, a communication center was organized, and thirdly, a security arrangement for the Coliseum and the surrounding area was imposed.

Communications could not be established with hospitals until police radio cars were dispatched to the

hospitals themselves. Major Funk indicated that there is still a question as to the legal responsibility of the Coroner at such disaster sites. He indicated that considerable reorganization has proceeded among the various police and fire agencies and the Offices of Civil Defense since the disaster.

### How One Hospital Responded

William H. Norman, M. D., vice-chairman of the Indiana Committee on Trauma of the American College of Surgeons, reported on the activities at the Methodist Hospital. He indicated that the first warning of the disaster was provided by one of the staff obstetricians who heard the report on his car radio enroute home. The hospital has had a number of experiences in the handling of large numbers of injured, treating some 60 patients and admitting 42 following the collapse of a scaffold in the Indianapolis Raceway in 1961. There is a large resident physician house staff and the hospital also has a nursing school so that sufficient numbers of professional help were available.

No patients were treated in the emergency room where only sorting was carried out. Sixty-five of some 120 survivors from the Coliseum disaster were admitted. The remaining 55 were treated and discharged. A shock ward was set up in the Recovery Room. Twenty-three major operations were carried out between midnight and 6:00 a.m. Sixty transfusions were administered. Forty-seven of the 65 patients were still in the hospital one week later; and 37 were still present two weeks later. There is one patient still left, but it is anticipated that he will be out by the anniversary of the disaster later this month.

He reported that there was fine interhospital support since the Indiana University Hospital provided a group of nurses to assist and augment the Methodist nursing staff.

Doctor Norman emphasized that this was a "family disaster" since many relatives were frequently admitted to the hospital from the same family group. There were also many losses among the families of the Methodist Hospital personnel.

He felt that the mobile litters should not be used as treatment litters as occurred in this hospital since it is imperative to have sufficient units available at the emergency room to provide interhospital transport for new or later arrivals. He felt that one of the reasons why the Methodist Hospital had performed well was because they had a disaster plan which had been rehearsed.

### At St. Vincent's Hospital

Joseph C. Finneran, M. D., Triage Officer, St. Vincent's Hospital, Indianapolis, indicated that this hospital was a 350 bed unit,  $1\frac{1}{8}$  miles from the scene of the disaster. It had no prior knowledge of the catastrophe until the first casualties arrived. A total of 105 arrived to the emergency room, including

three dead on arrival's. Of these, 41 patients were admitted. A staging area was set up in the Orthopedic ward and patients who were being prepared for surgery were shunted immediately to the Recovery Room. The Intensive Care Unit was used as a delayed treatment ward. Doctor Finneran was actually at home when the disaster occurred and learned of it during a telephone conversation with his mother in Boston. Among the many problems of sorting, Doctor Finneran reported that a sorting problem occurred in a patient with a broken nose who was shunted around the hospital several times before being treated and discharged.

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### Summarization and Conclusions On the Disaster Conference

Dr. Jackson summarized the conference by emphasizing the important points of discussion raised by each of the participants.

He felt that the announcement by Mr. Dodge, the Acting Chief of the Division of Health Mobilization, USPHS, that medical disaster planning at Federal level is going to include natural disasters in a very realistic way. It was probably the most important announcement of the day. This "parallel emphasis" upon the needs of communities in terms of natural disasters, Dr. Jackson felt would receive considerable support from the medical and health professions.

The reports on the five disasters discussed in some detail by the participants in the conference emphasized the following:

1. The need for effective communications between the disaster site and medical facilities.
2. An effective organization at the disaster site including medical control and command of survivors.
3. An effective properly controlled transportation system from the disaster site to medical facilities.
4. The need for hospital disaster plans to be made promptly effective by frequent testing and re-evaluation.

Dr. Jackson emphasized that the role of the Red Cross in terms of emergency welfare services has been exemplary for many decades and in particular, in the disasters related during the conference. However, he emphasized that medical services in times of disaster are available only through the organizations of the medical profession. The requirements for such emergency medical services can only immediately meet through the local physicians and established medical facilities. There is currently no formal agreement between the medical profession and the National Red Cross other than mutual respect and cooperation in terms of disaster services.

Dr. Jackson outlined the current program of the Committee on Disaster Medical Care of the American

Medical Association. He indicated that his Committee was working toward the development of a "disaster conscience" for each physician in order that his role in terms of disaster medical care could be identified.

Secondly, he stated that the Committee was in the process of defining and attempting to establish a *science of disaster medicine* and was in the process of preparing an Index of Disaster information as a basis for a comprehensive manual on disaster medical services.

A Disaster Survey Center has been proposed by his Committee and this proposal is currently under review by the Committees on Trauma and Shock of the Medical Sciences Division of the National Research Council.

Dr. Jackson further emphasized that the A. M. A. Committee was attempting to unite all professional medical societies in a comprehensive plan and program for responsible physicians in terms of emergency medical services for communities. He indicated that his Committee would continue to provide an annual scientific conference for physicians and Allied Health personnel, as well as practical workshops in the form of regional meetings held for the benefit of state and county medical societies, health departments, hospital administrators, MEND coordinators, and the various Committees on Trauma of the American College of Surgeons. His Committee also will continue to maintain liaison with all Federal agencies and will attempt to foster more regional and area planning.

In support of the concept of a science of disaster medicine, Doctor Jackson felt that considerable research and investigation is still necessary to provide modern sophisticated medical services at disaster sites as well as in hospitals. He felt that continued research is necessary for the development of effective blood substitutes in the treatment of shock, as well as in the field of antibiotics, wound care, resuscitation, etc., in the terms of mass casualty medical care. He particularly felt it was necessary to re-establish the management of *trauma* as an important part of the medical curriculum of the medical schools and of the therapeutic armamentarium of all physicians.

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### Public Health Service Sponsors Heart Program in Cleveland

The Region V office of the United States Public Health Service has announced plans for a Heart Disease Control Program seminar to be held in Cleveland, at the Statler-Hilton Hotel. Participants are expected to come from Wisconsin, Illinois, Indiana and Michigan as well as Ohio. The meeting will begin with registration on Tuesday, February 16 at 2:00 p. m. and end on the afternoon of Thursday, February 18.



# Special Session Roundup . . .

## Important Actions Taken by Ohio General Assembly During Mid-Winter Session Called by the Governor

By Hart F. Page

A NEW Toledo State Medical School; salary raises for county coroners; the redistricting of Ohio for election of Congressmen; and the establishment of a mechanism for reapportionment of the Ohio House of Representatives by Constitutional Amendment were major items of interest to Ohio physicians accomplished by the Special Session of the Ohio General Assembly, convened November 9, and adjourned sine die December 29, 1964.

### Toledo State Medical School

Named by Governor Rhodes to the nine-member Board of Trustees of the Toledo State College of Medicine were Drs. Frank F. A. Rawling (term ending May 1, 1969) and Byron Grant Shaffer (term ending May 1, 1968). Both are past-presidents of the Academy of Medicine of Toledo and Lucas County. Publisher Paul Block, Jr., of the *Toledo Blade* is acting Chairman of the Board.

The choice of Toledo as the site for Ohio's fourth medical college was a recommendation to the Legislature by the Ohio Board of Regents, the State's nine-member master planning agency for higher education, which was established by an act of the General Assembly in 1963. House Bill 7 establishing the new medical school in connection with the University of Toledo was signed by the Governor on December 18 and as an emergency measure, became effective immediately.

Cost estimates for the basic science facility, and affiliated hospital, indicate a capital outlay of from 30 to 40 million dollars. An entering class of 100 students is anticipated in about four years.

Witnesses appearing in support of the legislation were of the opinion that the basic science unit might cost \$12 million, with two-thirds coming from federal matching funds, and that the 500-bed teaching hospital might cost \$27 million, with part of that amount available from the Hill-Burton program.

Capital funds to get the program under way, in the amount of \$7.5 million will be contained in a \$290 million state development bond issue proposal to be submitted to the voters in May.

### Cleveland State University

The passage of House Bill 2, creates the Cleveland State University, the effective date of the meas-

ure being December 18. Named to the Board of Trustees was Dr. Middleton H. Lambright, president of the Cleveland Academy of Medicine.

### Coroner Salary Increases

Contained in Sub. House Bill 15, raising salaries of the members of the Ohio General Assembly and of statutory county officials were increases for county coroners.

Classified on a basis of county population the additions to annual salaries of coroners were as follows:

Classes	Population Range	Salary Increases
1 and 2	1 to 20,000	\$ 450
3 thru 6	20,001 to 40,000	600
7 thru 18	40,001 to 100,000	900
19 thru 25	100,001 to 175,000	1050
26 thru 29	175,001 to 400,000	1200
30 thru 34	400,001 to 1,500,000	1500
35	1,500,001 and over	1500

### Legislators' Pay Raised

Members of the Ohio Senate and the Ohio House of Representatives were raised from five to eight thousand dollars a year. Each member will continue to receive a travel allowance of ten cents a mile each way for mileage once a week during the session from his place of residence to Columbus and return.

The salaries of the President Pro Tempore of the Senate and the Speaker of the House were raised from \$7500 a year to \$10,500. The Speaker Pro Tempore of the House and the minority leaders of the Senate and House were upped from \$6250 to \$9250.

### Congressional Redistricting

Sub. House Bill 18, providing for 24 congressional districts, thus eliminating the present at-large election for one member of the U. S. House of Representatives from Ohio, and revising the boundary lines of most present congressional districts was passed and will be in effect beginning with the 1966 election.

The new 24th district consists of Butler, Warren and Preble Counties and a portion of Montgomery County to the west and south of the city of Dayton. The rest of Montgomery County will be the 3rd district.

Hamilton and Cuyahoga Counties continue with the same number of districts with the boundaries al-

tered a bit to more nearly equalize the populations. Lucas County remains as the 9th district with no boundary change.

Summit County becomes the 14th district with the exception of the northern part of the county and two townships on the Portage County side.

Mahoning County is divided, with the northern part and the city of Youngstown staying in the 19th and the remaining portion joined with Stark and Carroll Counties to form the 16th district.

Franklin County is divided into two districts, 12th and 15th.

For convenience in noting the changes in the above metropolitan districts, and for the rearrangements involving the other Ohio counties, *The Journal* presents the accompanying maps, showing the present districts and those effective for the 1966 elections.

#### Reapportionment of Ohio House

Due to a ruling of the United States Supreme

### Congressional Districts — Present Boundaries



This map of Ohio shows the boundary of districts from which Ohio's Representatives to the U. S. Congress were last elected. Twenty-four Congressmen were elected, one from each of the 23 Districts, and one at-large.



# Congressional Districts — Effective for 1966 Elections



This map shows new boundaries that will apply for elections in 1966 and for future years. One member of Congress will be elected from each of 24 Districts, eliminating the at-large member.

Court invalidating the "Hanna Amendment" in the Ohio Constitution, which guaranteed to each county, regardless of population, at least one member in the Ohio House of Representatives, the Legislature took steps to provide for compliance with the court action.

A subsequent order of the United States District Court gave the General Assembly until the end of 1965 to devise a new plan else the court itself would make the changes.

The passage of House Joint Resolution 1 during the Special Session will bring to the voters of Ohio

on May 1, an amendment to Article XI of the Ohio Constitution which will need a majority for approval.

It would provide for an expanded Apportionment Board consisting of the Governor, Auditor of State, Secretary of State, one member from each the majority and minority party in the Senate and one member from each party in the House. The Board would reapportion the House in 1965 and following each Federal decennial census.

Under the provisions of the amendment, the population of Ohio would be divided by 140 to determine

the "representative ratio." At the present time, using the 1960 census, the "ratio" would be about 70,000. In general, each member of the House would represent a population approximating one "ratio."

In the largest counties, with two or more congressional districts, Ohio House members would be elected at large from the congressional districts within the county, with one representative for each "ratio" of population. Remaining population after an even division among the congressional districts would provide a representative at large from the county, if sufficiently large to constitute a "ratio," or substantially equal to that number.

The representatives from counties containing one or more whole congressional districts, plus territory of another congressional district would be elected at large from the county or at large from the congressional district or districts. The remainder of the county would be attached to another representative district or would itself be a representative district.

In counties having a population entitling them to more than one representative, one or more representatives would be elected at large from the county as a whole. One representative would be allotted for each full "ratio" of population and one representative could be allotted for population substantially equal to a "ratio." Portions of the county not substantially equal to a "ratio" could be placed in other districts.

Those counties having a population substantially equal to one "ratio" would be allotted a representative or combined with other areas to form a representative district.

The counties having a population of less than a "ratio" and not otherwise allotted representatives would be combined to form representative districts "in conformity to the requirements of Article XI of the Ohio Constitution, the United States Constitution, federal laws, and the judicial interpretation thereof in force at the time of each formation of an apportionment plan."

The Apportionment Board would observe insofar as possible district lines established in earlier apportionments, county lines, compactness of districts and economic and community interests. Districts would have to be comprised of contiguous territory.

Changes in the apportionment for the election of the Ohio Senate are not contemplated at this time.

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Beginning in 1965, important changes are being made in the procedure of application and schedule of examinations of the American Board of Obstetrics and Gynecology. Applicants are invited to write the office of the Secretary-Treasurer, Clyde L. Randall, M.D., 100 Meadow Road, Buffalo, N. Y. 14216 for instructions.

## Sports Injuries Conference Is Scheduled in Akron

The first Northeast Ohio Sports Injuries Conference has been set for Saturday, April 3, in Memorial Hall at The University of Akron. Sponsor of this program is the Summit County Medical Society, 437 Second National Bank Bldg., Akron, with the assistance of the SCMS Research and Educational Fund.

The meeting will start at 9:00 a.m. and end at 5:00 p.m. The program is as follows:

### Morning Session

**Welcome** — Dr. Norman Auburn, president, Akron University; and Dr. Wendell Bucher, president, Summit County Medical Society

**The Physiology of Exercise** — Lawrence A. Golding, Ph. D., Kent State University; and Dr. John D. Kramer, Children's Hospital, Akron

**Adaptation of Physical Fitness Programs to the Individual** — Dr. Joseph D. Godfrey, professor of orthopedics, University of Buffalo; team physician, Buffalo Bills Professional Football Team

**Physical and Emotional Characteristics of the Young Athlete** — Dr. Thomas Shaffer, pediatrician, Ohio State University

### Panel Discussion —

Dr. Golding, Dr. Kramer, Dr. Godfrey, and Dr. Shaffer

### Afternoon Session

**Knee Injuries — Prevention, Diagnosis and Treatment** — Dr. Jack C. Hughston, orthopedic surgeon, Columbus, Ga., team physician, Auburn University

### Panel Discussion —

Invited Guest: Dr. Jack Hughston  
Team Physician: Dr. John Schlemmer, Akron  
Orthopedist: Dr. Walter Brown, Akron  
Athletic Coach: Gordon K. Larson, Akron University

Athletic Director: Otho Davis, Kent State University

Moderator: Charles Herndon, Ph. D., professor of orthopedic surgery, Western Reserve University College of Medicine

**Prevention, Diagnosis and Treatment of Athletic Injuries of the Ankle** — Dr. Joseph D. Godfrey

### Panel Discussion

Guest Speaker: Dr. Godfrey  
Athletic Director: William M. Edwards, Ph. D., Wittenberg University

Athletic Trainer: Leo Murphy, Cleveland Browns  
Track Coach: Thomas Evans, Akron University  
Athletic Coach: Ed Finnegan, Western Reserve University

Orthopedist: Dr. Buel Smith, Akron

Moderator: Dr. E. L. Mollin, or D. I. Minnig



## Toledo Medical School Board Named by the Governor

Governor James A. Rhodes recently appointed a board of nine trustees for the newly authorized college of medicine in the Toledo area. Following are their names, identification and term of office:

Bernard R. Baker, Perrysburg, attorney; seven years.

Paul Block, Jr., publisher of *The Blade*, Toledo newspaper; eight years.

J. Slater Gibson, attorney and legal adviser to the Toledo Board of Education; three years.

W. W. Knight, Jr., investment company executive, and chairman of the Toledo-Lucas County Port Authority; six years.

Sister Mary Lawrence, president of Mary Manse College; two years.

J. Preston Levis, Ottawa Hills, chairman of the board of the Owens-Illinois Glass Company; nine years.

Dr. Frank F. A. Rawling, Toledo physician and president of the Toledo Area Medical College and Education Foundation; five years.

Dr. Byron G. Shaffer, Ottawa Hills, surgeon; four years.

John A. Skipton, Findlay, head of the public affairs department of the Marathon Oil Company; one year.

The bill creating the medical school was passed by

the recent special session of the Ohio General Assembly and signed by the Governor in December. In a proposed bond issue to be submitted to the voters of Ohio in May, \$7.5 million is earmarked for construction of the medical school. Federal funds also are available for medical school construction.

## Ohio Ranks Second in Nation In Cancer Prevention Study

American Cancer Society volunteers in Ohio participating in the massive Cancer Prevention Study ranked second in the nation in tracing original subjects when the fourth follow-up was completed during the last fiscal year.

The Ohio Division, American Cancer Society, reported that in 1959, some 88,527 Ohio men and women enrolled in the six year study, which has been called "the largest medical statistical research study ever undertaken." They were part of more than one million persons throughout the country who agreed to provide ACS with confidential information about their health, living habits, occupation, etc., for the next six years.

At the completion of the fourth follow-up in early 1964, the 5000 Ohio volunteer researchers were able to trace and confirm the health status of all but one-half of one per cent of the original 88,527 persons. The information obtained was forwarded to the National American Cancer Society in New York for analysis.

## Deadline for Submission of Resolutions to Columbus Office of the Association Is March 10

**D**ELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1965 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal*, must be introduced at the first session of the House of Delegates, Sunday evening, May 9, at the Columbus Plaza Hotel.
2. When the resolution is introduced, copies in triplicate should be presented.
3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 10. This requirement may be waived by a two-thirds majority of the House of Delegates.
4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

# Annual Meeting Highlight . . .

## The Cancer Conference, with Outstanding Speakers, A Feature of the OSMA Meeting in Columbus, May 9-14

**T**HE CANCER CONFERENCE, a program that has drawn special interest from Ohio physicians in the past, will again be a feature of the 1965 OSMA Annual Meeting, in Columbus, May 9-14. The Conference, scheduled on Wednesday morning, May 12, is jointly sponsored by the OSMA and the Ohio Division of the American Cancer Society, with the program arranged by the Cancer Society.

Here are highlights of the program, including names of outstanding speakers and subjects to be presented:

Presiding: Wilford D. Nusbaum, M.D., Lancaster, chairman of the Eighth Annual Cancer Conference.

Welcome, Dr. Nusbaum and Robert E. Tschantz, M.D., Canton, President of the Ohio State Medical Association.

Cancer of the Stomach and Esophagus, Gordon McNeer, M.D., New York City, attending surgeon, Memorial Hospital.

Cancer of the Genitourinary Tract, Harry Grabstak, M.D., New York City, associate attending surgeon, Memorial Hospital.

Leukemia, Daniel Bergsaged, M.D., Houston, Texas, Department of Medicine, M. D. Anderson Hospital & Tumor Institute, Texas Medical Center.

Chemotherapy of Solid Tumors in Relation to the Head and Neck, R. H. Jesse, M.D., Houston, Texas, associate surgeon, Head and Neck Service, M. D. Anderson Hospital.

Panel Discussion — (Speakers to be announced)

This is one of many features in store for physicians at the Annual Meeting.

Surgery — On Monday afternoon, May 10, the Ohio State Surgical Association will present a program for its members and for other physicians interested.

Trauma — On Tuesday afternoon, May 11, the Ohio Committee on Trauma of the American College of Surgeons will present a program in this specialty.

Heart — On Thursday morning, May 13, the Ohio State Heart Association will present a program on the theme "Drug Therapy of Cardiac Disease."

OSU Faculty Presentations — On Friday morning, in a General Session program arranged by the faculty of the Ohio State University College of Medi-

cine, 12 physicians will give 10-minute talks each on the topic, "What I Do About . . ."

History — For the first time, the Ohio Academy of Medical History will meet in conjunction with the OSMA Annual Meeting. Their program will be held on Sunday afternoon, May 9. This is an excellent opportunity for physicians who are interested in medical history to meet with this group.

These are only a few of the many features of the 1965 Annual Meeting. Following are programs scheduled on three afternoons:

### Wednesday Afternoon

Section on Internal Medicine and the Ohio Society of Internal Medicine.

Section on Occupational Medicine.

Section on Physical Medicine and the Ohio Society of Physical Medicine and Rehabilitation.

First session of Ohio Health Commissioners' Institute.

### Thursday Afternoon

Section on Anesthesiology and Section on General Practice of Medicine.

Section on Ophthalmology and Ohio Ophthalmological Society.

Section on Ear, Nose and Throat.

Section on Radiology and the Ohio Chapter of the American College of Chest Physicians.

Conference on Laboratory Medicine.

Second session of the Ohio Health Commissioners' Institute.

### Friday Afternoon

Section on Neurological Surgery and Ohio Neurosurgical Society.

Section on Obstetrics and Gynecology.

Section on Pathology and the Ohio Society of Pathologists.

Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics.

Section on Psychiatry and Neurology and the Ohio Psychiatric Association.

### Other Features

Scientific and Educational Exhibit — The exhibit area is always a popular place for physicians to browse through and chat with their colleagues about developments in research and other fields of medicine and surgery.

The Technical Exhibit — Detail men from pharmaceutical and other supply houses will be on hand

*(Text continued on page 168)*



## Leading Downtown Columbus Hotels and Prevailing Rates

### COLUMBUS PLAZA HOTEL (Headquarters)

50 N. Third Street

Singles ..... \$11.50 - 15.50

Twins ..... 14.00 - 19.00

### DESHLER-COLE HOTEL

W. Broad & N. High Streets

Singles ..... \$ 7.50 - 14.50

Doubles ..... 12.00 - 18.00

Twins ..... 13.00 - 20.00

### NEIL HOUSE

41 So. High Street

Singles ..... \$ 8.50 - 15.00

Doubles ..... 12.00 - 18.00

Twins ..... 12.00 - 20.00

### HOTEL SOUTHERN

So. High & E. Main Streets

Singles ..... \$ 8.00 - 8.50

Doubles ..... 11.00 - 11.50

Twins ..... 11.50 - 13.00

### CHRISTOPHER INN

300 E. Broad Street

Singles ..... \$10.00 - 12.50

Doubles ..... 13.00 - 15.00

Twins ..... 17.00 - 18.00

### PICK-FORT HAYES HOTEL

31 W. Spring Street

Singles ..... \$ 7.50 - 13.00

Doubles ..... 12.00 - 14.00

Twins ..... 12.50 - 18.00

*All of the above rates include  
overnight parking of automobile.*

If you plan to share a room, please indicate name  
of roommate so the hotel may avoid duplicate  
reservations.

## *Make Your* HOTEL RESERVATIONS

*... Now*

for the

## 1965 Annual Meeting

Ohio State Medical Association

COLUMBUS

MAY 9 - 14

### HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

\_\_\_\_\_  
(NAME OF HOTEL)

\_\_\_\_\_  
Columbus, Ohio  
(ADDRESS)

Please reserve the following accommoda-  
tions during the period of the Ohio State  
Medical Association Annual Meeting,  
May 9 - 14 (or for period indicated)

☐ Single Room

☐ Double Room

☐ Twin Room

Other accommodations \_\_\_\_\_

Price range \_\_\_\_\_

Arriving May \_\_\_\_ at \_\_\_\_ A.M. \_\_\_\_ P.M.

PLEASE VERIFY MY RESERVATION

Name \_\_\_\_\_

Address \_\_\_\_\_

to talk to physicians personally about their products and services.

**The President's Reception** — The social highlight of the 1965 Annual Meeting. Members and their ladies can look forward to an early evening of relaxation and dancing. No dinner, no program. Hors d'oeuvres will be furnished; cash bar available.

**The House of Delegates** — Meets first on Sunday evening, May 9, and again on Tuesday evening. Reference committee meetings on Monday and, if necessary on Tuesday.

**The Woman's Auxiliary** — The ladies will meet at the Christopher Inn. All physicians' wives are urged to attend sessions.

### Two Places to Keep in Mind

**Columbus Plaza Hotel** — A new downtown motor hotel. Meetings of the House of Delegates, the President's Reception and some other features will be held here. See hotel reservation page in this issue for other downtown Columbus hotels, room rates, reservation blank, etc.

**The Veterans Memorial Building** — At 300 W. Broad Street, a short distance from downtown hotels, this auditorium will be the scene of most of the scientific features of the program and the exhibits.

Watch for the complete program in the March issue of *The Journal* — names of speakers, subjects to be discussed in the various sessions, where programs will be held and other information about the 1965 Annual Meeting.

### Rapid Progress Seen in Protection By Medical Insurance Programs

Health insurance protection which helps to pay the costs of doctor calls and other non-surgical care by physicians is growing rapidly, the Health Insurance Institute announced.

This type of protection, known as regular medical expense coverage, has grown from 42,684,000 persons insured at the end of 1953 to 102,177,000 persons insured at the end of 1963, according to the Institute.

The growth of this coverage is one measure of how the American people have materially broadened their health insurance protection over the past ten years, the Institute said.

At the end of 1953, more than 97 million Americans had hospital expense coverage, indicating that more than four out of every ten persons with hospital insurance also had regular medical coverage.

At the end of 1963, more than 145 million persons had hospital insurance, so that seven out of every ten persons with hospital insurance now have regular medical protection, said the Institute.

The American Physical Therapy Association will hold its 42nd Annual Conference in Cleveland, Ohio, June 27 through July 2, 1965.

### Have You Given Us Your Opinion In the Readership Survey?

In the January issue of *The Journal* on the last page was a postal card questionnaire which readers were asked to return with their comments.

Some excellent suggestions for improving *The Journal*, as well as some pointed criticisms, have been coming into the office. At the time this issue went to press, answers had been received from physicians who indicated "chief professional interest" in more than 25 fields of medicine and surgery.

*The Ohio State Medical Journal* is holding up well among "the professional journals I read, in order of preference." An exceptionally high percentage of physicians indicated that they read the pharmaceutical advertisements "often" and "occasionally."

As soon as the staff has had an opportunity to tabulate the results of this readership survey, a report will be published in *The Journal*.

If you have not returned this postal card questionnaire, please refer to the January issue of *The Journal*, last page, and return the card with your comments.

### Cleveland Unit Is Cited for Its Outstanding Cancer Survey

The Cuyahoga Unit of the American Cancer Society has received a national honors citation for its "outstanding accomplishment" in the PAP program to conquer uterine cancer.

The citation was voted by the national board of the American Cancer Society.

The program, cosponsored by the Academy of Medicine of Cleveland, set a national record, with 205,022 women in Cuyahoga County taking the PAP test from April 1, 1963, to April 1, 1964. During this period *The Plain Dealer* ran frequent reminders emphasizing the need for early detection of uterine cancer.

Of the women taking the test, 498 were found to have cancer in its early, easily curable stage, and 2,019 were found to have some sort of abnormal reaction. — *Cleveland Plain Dealer*.

Four leading Akron rubber companies — Firestone Tire & Rubber Company, The General Tire & Rubber Company, The B. F. Goodrich Company, and The Goodyear Tire & Rubber Company — have given a total of \$120,000 to the University Medical Center Development Program of Western Reserve University, Cleveland.



# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*

— Justice Robert H. Jackson in *AAA Supreme Court Case*, 1942

## IF THE DOCTORS DON'T, OTHERS WILL

A member of the profession in Ohio made a telling point in regard to physician participation in health facilities planning for the community, and offered some pertinent advice for all doctors of medicine.

Dr. Frank F. A. Rawling, of Toledo, declared that the urgency of long-range planning "boils down to the fact that either we, who are actively involved in what might be called marketing this product of medical care, must also become actively interested in long-range planning, else it will be done for us by those who cannot do it with the perspective that we possess."

Dr. Rawling was speaking at the First National Conference on Areawide Health Facilities Planning held in Miami Beach, on the topic, "Planning for an Urban Community." He was speaking from a vast experience in medical organization work and community services as well from his background in professional and hospital work. Among his appointments he is a trustee of the Toledo Hospital Planning Association, is chairman of the OSMA Judicial and Professional Relations Committee and has served several times as Reference Committee chairman for the OSMA House of Delegates.

No one knows the needs of his own community as well as the doctor, Dr. Rawling further said. Likewise, no one knows as well as members of the medical profession "the standards to be met if high level or quality care is to be maintained."

These points are well taken. If doctors don't take this responsibility, others will.

## NEW MEDICAL SCHOOL FOR OHIO — GOOD NEWS FOR THE PROFESSION

Recent action by the Ohio General Assembly to make the proposed medical school in the Toledo area a reality is welcome news. Ohio can be justly proud of its three medical schools of long and honorable standing. In this era of expanding population and increased consciousness on the part of the people

for better health care, an additional medical school is a welcome entity.

"Medical education is entering an active period of growth in the United States, perhaps the period of greatest growth in its history," a recent editorial in *The Journal of the AMA* stated. . . . "There will be more medical schools and more teaching hospitals, more medical students and more faculty, more continuing education and more paramedical education, more research and more service in the medical center. . . ."

The latest report of the AMA Council on Medical Education indicates that there is renewed interest on the part of select students to enter the medical field. "This follows a period of about eight years of relative scarcity of applicants, during which the percentage of A students in the entering classes had also declined somewhat," the editorial comment states. The increased interest speaks well for the future of the medical profession.

In its editorial comment, *JAMA* laments that "size and complexity seem to be increasing with equal rapidity." In Ohio there has been excellent liaison between the medical schools and the profession as a whole. With the entry of a new medical center in the State, "size" is indeed part of the picture, but "complexity" can be brought to a minimum by continued liaison between physicians in all fields of medicine and those dedicated to the art and science of teaching.

## APPREHENSION FOR THE FUTURE, A MARK OF THE PROFESSION

The traditional image of the family doctor may prompt many a physician to long for "the good old days" of medicine. That stalwart individualist who looms from the past stimulates every conscientious doctor to stand a bit taller in the profession and to look with some apprehension on the future.

It was this same way more than a hundred years ago. The very period which gave us the traditional family doctor was looked upon with apprehension, as indicated by the following historical note:

"I repeat, our profession has declined in public

estimation within the present century, whilst it has been advancing in its claims and merits beyond all precedent. Mankind appear to have but little more respect for it now than in the days when medical science was but a jumble of superstition and empiricism, and when its practitioners were banished from Rome as public pests. To make such an acknowledgment is disagreeable; but if the contemplation of the picture should lead to an effort to correct the evil and bring about a better state of things, the confession may prove salutary." — Excerpt from an address by Dr. Henry Gibbons in 1849.

The confession does indeed prove salutary. Fortunately many physicians of today are looking on the future of the profession with apprehension, determined to pass on to the future that same high tradition that has prevailed for so many generations.

The OSMA Joint Committee on Family Practice has been working diligently along just such lines in an effort to preserve the image of the doctor as the central figure in the present and future art and science of medicine.

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#### A MARTYR TO MEDICINE AS WELL AS RELIGION

The martyrdom of Paul Carlson, M. D., in the Congo marked the climax in the career of a man whose life was doubly dedicated. Primarily he was in the Congo because of a conviction that his faith was something to pass on to his fellow man. Yet, in a still broader sense, his last actions and the few final words that are recorded, indicate a more immediate purpose; a determination to stay where he was needed and minister through the art and science of medicine.

Dr. Carlson lived and died in the true spirit of the medical missionary, one of those stalwart individuals whose pioneering efforts have opened the door to civilization in many a backward area.

The black part of this picture is that Dr. Carlson died, not because he was working in a backward country, but because of a diabolical plot to destroy the seeds of freedom and individual dignity.

Little has been said about great areas of the Congo where American medical missionaries are quietly going about their dedicated tasks; working in harmony with local authorities, training young natives to someday take their places, and in general making the United States look like a true Uncle Sam to a less fortunate people.

Great credit goes to the Peace Corps and to the work it has been doing, but little has been said about that other peace corps, the medical missionary movement that has been painting a good picture of Uncle Sam to backward nations for generations. In terms of peace and good will to men, time undoubtedly will tell that Dr. Carlson's life has not been given in vain.

## Internal Revenue Offices Are Ready to Help Taxpayers

A special announcement from the Internal Revenue Service states that local offices of the IRS are prepared to assist taxpayers with their current tax questions and will be open during regular business hours through April 15.

For example, John Sharpe, IRS administrative officer in Columbus, announced that the office at 197 E. Gay Street, will be prepared to assist taxpayers in the Columbus area Monday through Friday, during regular business hours (with the exception of February 22). "Many taxpayers have questions that could be promptly answered if they used our telephone service," he said. For the Columbus office, the special number is 224-2241.

Special numbers have been announced in other areas, he said. In some of the smaller cities, offices are limited to perhaps one or more days a week, depending on the staff available. Taxpayers are urged to complete as much of the tax forms as possible themselves before visiting the office.

Readers of *The Journal* are referred to the December issue and the article entitled "Tax Roundup for the Physician" for information about Federal and State taxes. Because of the complicated nature of their returns, many physicians like to enlist the help of a tax consultant.

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## 81.5 Million Persons Have Chronic Conditions

Chronic illnesses and bodily impairments affect over four out of every ten Americans, the Health Insurance Institute announced.

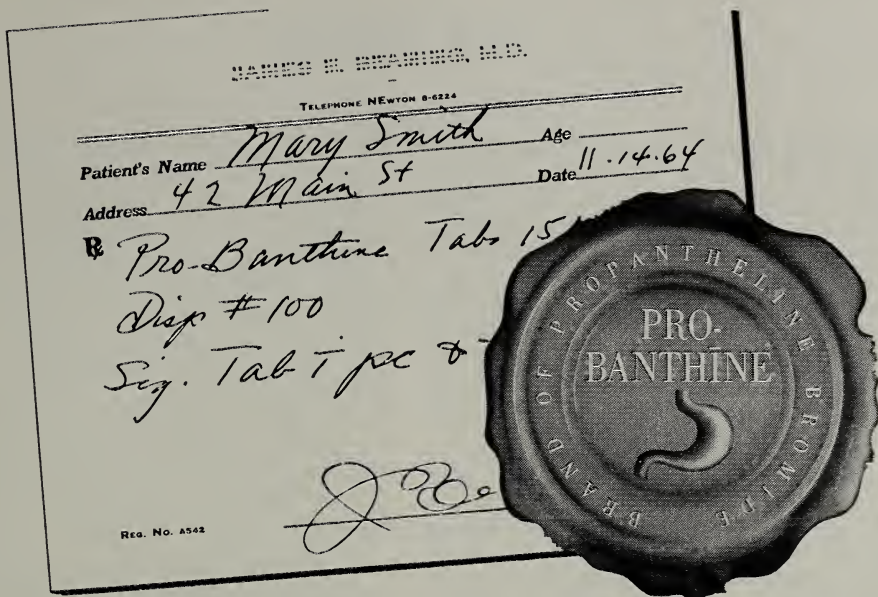
The Institute, reporting on U. S. National Health Survey data, said that 81.5 million persons in the U. S. have one or more chronic conditions. A sampling of these conditions would include illnesses such as hay fever, asthma, diabetes, high blood pressure, ulcers, and others; and impairments such as hearing defects, deafness, paralysis of any kind, any condition present since birth, etc.

The NHS study, which covers the period from July 1962 to June 1963, revealed that of the 81.5 million people with one or more chronic conditions, 58.8 million, or over 72 per cent, were able to carry on with their major activities — such as working, housekeeping, going to school, and so on. And nearly 22.7 million persons were unable to carry on normal activities.

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The Merck Company Foundation announced a \$90,000 annual program of grants for postgraduate study by foreign physicians in the United States, to help alleviate the worldwide shortage of clinical pharmacologists.





# Stamp of Approval on Virtually any Ulcer Regimen— **PRO-BANTHINE®** (propantheline bromide)

Historically, reduction of acid and motility in peptic ulcer has been approached through the use of antacids, dietary management and surgery.

Since 1953, however, Pro-Banthine used alone or in addition to other measures has contributed importantly to achieving both of these goals. It has been shown repeatedly that adequate doses of Pro-Banthine will significantly inhibit gastric acid secretion and reduce gastrointestinal motility.

So dependable have these actions been that now, for many, standard treatment of peptic ulcer and several allied conditions has become antacids *plus* Pro-Banthine, dietary management *plus* Pro-Banthine, surgery *plus* Pro-Banthine, or some combination of the three.

Pro-Banthine has become the most widely

prescribed anticholinergic for patients with peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia because patients respond favorably to its therapeutic actions.

**Side Effects and Precautions**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

**Dosage**—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six tablets daily in divided doses. In severe conditions as many as four tablets may be given four times daily. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

**SEARLE**

Chicago, Illinois 60680

*Research in the Service of Medicine*

# Ad Astra

**Robert Henry Brown, M.D.**, Cincinnati; Howard University College of Medicine, 1931; aged 58; died December 18; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician for about 29 years in the Cincinnati area, Dr. Brown also was associated with the Cincinnati Health Department for a number of years. During World War II, he served in the Army Medical Corps. A member of the Presbyterian Church, he is survived by his widow, a son, two daughters, a sister and three brothers.

**John Henry Caldwell, M.D.**, Warren; Ohio State University College of Medicine, 1917; aged 74; died December 27; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. A native of Athens County, Dr. Caldwell began his practice in Wheeling, W. Va., and moved to Warren in 1922. His specialty was anesthesiology. A veteran of World War I and a member of the Presbyterian Church and several Masonic bodies, he is survived by his widow, a daughter and a son, Dr. George E. Caldwell, also of Warren.

**Harvey Franklin Doe, M.D.**, Edgerton; Jefferson Medical College of Philadelphia, 1936; aged 68; died December 10; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Edgerton for about 12 years, Dr. Doe came to Ohio from Maine. He was a veteran of World War II, and was a member of the American Legion. Other affiliations included membership in the Methodist Church, the Rotary Club and the Masonic Lodge. His widow and a daughter survive.

**John Hudson Elias, M.D.**, Glouster; Wayne State University College of Medicine, 1908; aged 82; died December 28. A native of Southeast Ohio, Dr. Elias served all of his professional career there, and for 18 years was Athens County coroner. He was a member of the Presbyterian Church and the Masonic Lodge. Surviving are his widow and two sisters.

**Kimsey Conklin Evans, M.D.**, Payne; Indiana Medical College, School of Medicine of Perdue University, 1906; aged 82; died December 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Evans served the greater part of his professional career in the Paulding County community. A veteran of World War I, he was a member of the United Church of Christ

and several Masonic bodies. Among survivors are his widow, two daughters and a son.

**Maurice David Friedman, M.D.**, Cleveland Heights; University of Michigan Medical School, 1924; aged 66; died December 25; member of the Ohio State Medical Association, the American Medical Association, American Academy of Neurology, and American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. A practicing physician in the Cleveland area for many years, Dr. Friedman was chief of neurology at Mt. Sinai Hospital and was a past-president of the Cleveland Society of Neurology and Psychiatry. A member of the Temple, he is survived by his widow, a daughter and a sister.

**Carl Ernst Friedrich, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1920; aged 80; died December 1; former member of the Ohio State Medical Association. A practicing physician for more than 42 years in the Madisonville area of Greater Cincinnati, Dr. Friedrich was a member of the Lions Club, and the Kiwanis Club. He is survived by two sisters.

**Gordon Maxwell James, M.D.**, Marietta; University of Oregon Medical School, 1928; aged 68; died December 13 in the Chillicothe Veterans Hospital after a long illness; former member of the Ohio State Medical Association. Dr. James began his professional work in the Pacific coast states, and later practiced for about three years in Marietta. A Naval Reserve officer, he was called to active duty early in World War II. Surviving are his widow, a son, two daughters and two sisters.

**Harry C. Kendall, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1927; aged 66; died December 7; member of the Ohio State Medical Association, the American Medical Association and the American Academy of pediatrics; diplomate of the American Board of Pediatrics. A practicing physician in Cincinnati for many years, Dr. Kendall was associated with a number of organizations concerned with child health, and was a former physician for the local health department. He was a veteran of World War I. Survivors include his widow, a son, three sisters and a brother.

**Frank Gordon Lawyer, M.D.**, Cambridge; Ohio State University College of Medicine, 1926; aged 61; died December 14; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Dermatology



& Syphilology. A practicing physician in Cambridge for 37 years, Dr. Lawyer specialized in dermatology and radiology. He was a veteran of World War II, during which he served in the Medical Corps overseas. Affiliations included memberships in the American Legion, the VFW, Kiwanis Club, Elks Lodge and the Baptist Church. Survivors include his widow, a son, a sister and a brother, Dr. Ruskin B. Lawyer, of Columbus.

**Leo Robert Markey, M. D.,** Cleveland; Ohio State University College of Medicine, 1931; aged 58; died December 5; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A previous resident of Cleveland, Dr. Markey returned there to practice in 1944 after service in the Army Medical Corps during World War II. Among affiliations, he was a member of the Masonic Lodge, several fraternal groups and the Temple. Survivors include his widow, two sons, a daughter and a brother.

**Jacob Bernard Moses, M. D.,** Cincinnati; University of Virginia School of Medicine, 1895; aged 93; died December 13. Dr. Moses practiced for many years in Crestline, moving to Cincinnati about 15 years ago. Surviving are his widow, a daughter and a sister.

**Thomas Adams Munns, M. D.,** Sepulveda, Calif.; University of Cincinnati College of Medicine, 1927; aged 64; died November 31; former member of the Ohio State Medical Association. A former Oxford physician, Dr. Munns served in the Army Medical Corps during World War II and then went into Veterans Administration medical service. He was recently radiologist at the VA Hospital in Northridge, near Los Angeles. Surviving are his widow, two sons and a brother.

**Garnett Eglon Neff, M. D.,** Portsmouth; Ohio State University College of Medicine, 1926; aged 64; died December 12; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Neff practiced in Portsmouth for 37 years, his

entire professional career. A veteran of World War II, he served overseas with the 96th Evacuation Hospital. Among affiliations, he was a member and elder in the Presbyterian Church, a member of Phi Chi fraternity, the Masonic Lodge and the Elks Lodge. Survivors include his widow, a daughter and a grandson.

**Bernard Henry Nichols, M. D.,** Ravenna; Starling Medical College, Columbus, 1904; aged 88; died December 18; member of the Ohio State Medical Association, the American Medical Association, American Roentgen Ray Society, and Radiological Society of North America; diplomate of the American Board of Radiology. A pioneer in the x-ray field, Dr. Nichols was head of the x-ray department at the Cleveland Clinic for many years and later took a similar post at Robinson Memorial Hospital. A resident of Ravenna for much of his life, he served on the city council and on the local board of education. A veteran of World War I, he was a member of the American Legion and VFW; also a vestryman in the Episcopal Church. Survivors include his widow and a sister.

**Benjamin Spencer Park, M. D.,** Painesville; University of Buffalo School of Medicine, 1919; aged 69; died December 23; member of the Ohio State Medical Association, and the American Medical Association; fellow of the American College of Surgeons. Member of a pioneer family of the area, Dr. Park devoted a lifetime to the practice of medicine and public health in the Lake County vicinity. His early practice began at Fairport Harbor and was moved to Painesville in 1926. In recent years he was Lake County health commissioner, a post he accepted in 1959. Active in medical organization affairs, Dr. Park was long a member of the House of Delegates of the OSMA. He served as president of the Ohio State Public Health Association and the Ohio Health Commissioners Association. He was a veteran of both World War I and World War II, was a member of the Methodist Church, several Masonic bodies, the Elks Lodge, Kiwanis Club and



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other local organizations. Surviving are his widow, a daughter and a son, Dr. Benjamin S. Park, Jr., of New York.

**Thomas Arthur Picard, M. D.,** Ashtabula; Ohio State University College of Medicine, 1958; aged 30; died December 10; member of the Ohio State Medical Association and the American Medical Association. A native of Conneaut, Dr. Picard opened his practice in Ashtabula in 1959 after completing an internship at Mercy Hospital in Springfield. He was a member of the Catholic Church and the Knights of Columbus. Survivors include his widow, two children, his parents and two brothers.

**John Richard Plent, M. D.,** Shaker Heights; Western Reserve University School of Medicine, 1920; aged 69; died December 16; member of the Ohio State Medical Association. A physician for more than 40 years in the Greater Cleveland area, Dr. Plent belonged to several organizations including the Cleveland Medical Library Association. In addition to his professional associations, he was a past-president of the Cleveland Chapter of the Society of American Magicians. As a Catholic, he was a member of the Third Order of St. Francis. Survivors include his widow, a daughter and a son.

**Robert Burton Poling, M. D.,** Youngstown; University of Louisville School of Medicine, 1923; aged 74; died December 15; member of the Ohio State Medical Association, the American Medical Association, American College of Cardiology, American College of Allergists and the American Society of Clinical Pathologists. A past-president of the Mahoning County Medical Society, Dr. Poling practiced in the Youngstown area from 1923 until his retirement in 1960. His widow and a daughter survive.

**Richard Henry Schaefers, M. D.,** Wapakoneta; University of Nebraska College of Medicine, 1939; aged 49; died December 5; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician in Wapakoneta since 1949, Dr. Schaefers had served two terms as Auglaize County coroner and had been named to a third term. He served as an Air Force officer during World War II, and was a member of the American Legion and the VFW. Other affiliations included memberships in several Masonic bodies and the Lutheran Church. Survivors include his widow, a son, a daughter and his mother.

**Martin Hansen Vinkel, M. D.,** Crestline; Loma Linda University School of Medicine, 1929; aged 67; died December 23; former member of the Ohio State Medical Association. A medical missionary in China for the Seventh-Day Adventist Church, during his early career, Dr. Vinkel later established a practice in Crestline. He moved to Dayton two years ago. Surviving are a son and a daughter; his widow and two step-children; also four sisters in Denmark.

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# Activities of County Societies . . .

## Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

### GREENE

Dr. R. David Warner of Xenia was elected president of the Greene County Medical Society Thursday morning (Dec. 10) at Greene Memorial Hospital. He succeeds Dr. Norman Linton of Jamestown.

Other new officers include Dr. Ray W. Barry of Beavercreek, vice president, succeeding Dr. Carl Hyde of Yellow Springs, and Dr. Rudi Sotlar of Jamestown, secretary-treasurer, succeeding Dr. Richard Falls of Xenia.

Dr. Roger C. Henderson of Xenia was elected delegate to the Ohio State Medical Association for a two-year term, and Dr. Paul Vernier of Fairborn, who is serving the last of a two-year term, was named alternate.

Other members serving automatic and unexpired terms are Dr. Meinhard Robinow of Yellow Springs, Dr. Alvin B. Salisbury of Fairborn and Dr. Eugene J. Schmitt of Xenia, who comprise the board of censors.

Mrs. C. K. Elliott of 239 Pleasant St., will continue as executive secretary. She has served in this capacity since September, 1960.

Attorney Robert A. Miller of the firm, Miller, Finney and Clark, was a guest and spoke to members on behalf of the Greene County Bar Association. —*Xenia Daily Gazette*.

## Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

### SENECA

New officers of the Seneca County Medical Society were elected Tuesday night (Dec. 15) when the so-

ciety met in the Shawhan dining room with Dr. O. G. Burkart presiding.

The new officers are Dr. James A. Murray, Fostoria, president; Dr. Olgierd Garlo, Tiffin, vice-president; and Dr. Lowell K. Good, Fostoria, secretary-treasurer. Dr. Burkart is the retiring president.

Dr. Walter A. Daniel, Tiffin, was elected delegate, and Dr. Henry L. Abbott, Tiffin, alternate to the annual meeting of the Ohio Medical Association.—*Advertiser Tribune*, Tiffin.

## Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

### DEFIANCE

"Current Concepts of Coronary Artery Disease" was the subject of a talk by Dr. Parke Willis, associate professor of medicine at the University of Michigan Medical Center, at a meeting for area physicians in the Holiday Inn (Defiance) Thursday evening (Dec. 10).

This is the first in a series of four post-graduate medical lectures to be given the second Thursday of each month. They are co-sponsored by the Defiance County Heart Branch and the Defiance County Medical Society.—*Defiance Crescent News*.

## Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)


### ASHTABULA

About 90 persons attended a dinner Tuesday night (Dec. 8) honoring doctors in Ashtabula County who have served the sick for 25 years or more and

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(1) Frykman, H.M.: *Minn. Med.*, Vol. 38, Jan. 1955. (2) Poth, E.J.: *The J.A.M.A.*, Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: *Texas State Jour. of Med.*, Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: *Jour. of The Amer. Ger. Soc.*, Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: *N.Y. State Jour. of Med.*, Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: *Jour. of Oral Surg., Anes. & Hosp. Dental Serv.*, Vol. 19, July 1961. (7) Weekes, D. J.: *E.E.N.T. Digest*, Vol. 25, No. 12, Dec. 1963.

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who are still practicing medicine in the area. Setting was the Swallows Restaurant.

Attending were county society doctors and their wives. Dr. James Macaulay was master of ceremonies.

Officers elected for the coming year are Dr. Harmon O. Tidd, president; Dr. J. Richard Nolan, vice-president, and Dr. William F. Doran of Conneaut, secretary-treasurer.

The affair which began at 6:30 p. m. was arranged by Dr. Samuel Altier. Assisting him were Dr. Robert J. Zimmerman, Conneaut; Dr. John B. Hall, Geneva, and Dr. William F. Davis, Ashtabula. — *The Free Press*, Geneva.

## Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

### PORTAGE

More than 100 persons attended the annual Christmas party of the Portage County Medical Society, held at Twin Lakes Country Club.

### STARK

Dr. H. J. Bowman of Canton was installed Thursday night (Dec. 10) as president of the Stark County Medical Society.

Other officers named at the annual dinner meeting at Mergus Restaurant are Dr. A. R. Furnas of Massillon, president-elect; Dr. E. J. Davis of East Canton, re-elected secretary-treasurer; Dr. William D. Baker of Alliance, re-elected to the board of censors; Dr. M. F. Lieber of Canton, re-elected as delegate for three years to the Ohio State Medical Association, and Dr. E. E. Grable of Canton, elected as an alternate delegate.

Dr. G. O. Thompson of Alliance is the retiring president. — *Canton Repository*.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFFENBACH, M. D., MARTINS FERRY)

### TUSCARAWAS

The annual Christmas dinner party of the Tuscarawas County Medical Society and its Auxiliary was

a gay event last evening (Dec. 14) at the Reeves Motor Inn in this city (New Philadelphia) with fifty-one persons attending.

Dr. C. Raymond Crawley, president of the Medical Society, spoke briefly and introduced Mrs. E. R. Hammersley of Tuscarawas, president of the Auxiliary.

During the evening, contributions for the Auxiliary's AMA-ERF fund were placed in a large Christmas stocking. Money derived from a fruit cake sale also was placed in the fund for which Mrs. Roy A. Wilson of Dennison is the county chairman. — *Daily Times*, New Philadelphia.

## Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, M. D., ZANESVILLE)

### FAIRFIELD

Dr. V. A. Simiele, formerly of Logan, is the new president of the Fairfield County Medical Society.

The Lancaster physician, who succeeds Dr. James Beesley, assumed his new post in January.

Dr. George LeSar was elected vice-president and Dr. Stephen Hodsdon, Baltimore, was elected secretary-treasurer. — *Logan Daily News*.

## Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

### FRANKLIN

Dean Lewis, moderator of the WBNS Radio program "Open Mike," was honored at a recent meeting of the Academy of Medicine of Columbus and Franklin County. Dr. Homer A. Anderson, 1964 President of the Academy, presented Mr. Lewis a plaque in recognition of his excellent handling of the program on which a number of physicians have appeared.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

Forty-two physicians and four guests attended the regular meeting of Lorain County Medical Society

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on January 12 at Oberlin Inn. The meeting was preceded by a social hour and dinner.

President John W. Wherry, M. D., called upon Dr. M. G. Fisher, county health commissioner, to introduce three representatives from the U. S. Public Health Service, assigned to the Ohio Department of Health North East District as Syphilis Epidemiologists. They briefly outlined their work in this field and presented a program and film on the "Identification of Early Syphilis."

A letter from Perry R. Ayres, M. D., Editor of the *Ohio State Medical Journal*, was read, regarding the survey requested from physicians through a postal card questionnaire in the January issue of *The Journal*—and the members' attention was directed to the primary purpose of this survey.

A Memorial Address was read by Dr. Denis A. Radefeld for the late Roman Stetkevich, M. D., and all present stood in silent tribute to the memory of their esteemed colleague.

"Nursing Education in Lorain County" was the subject of a report given by John Halley, M. D., past-president of the Society.

Eleventh District Councilor, Lawrence C. Meredith, M. D., discussed the activities of OSMA in relation to the proposed increase in dues, Mr. Saville's request to assume the title of "Consultant" by reason of health, and the appointment of Mr. Hart Page as Acting Executive Secretary. He drew attention also to matters of legislative interest and the Scientific Exhibit.

Before adjournment, Dr. Wherry announced the program for the February meeting, after which the showing of the AMA Film on their Retirement Plan was featured.

Dr. Edward P. Radford, Jr., nationally-known Harvard University expert in public health and physiology, will join the University of Cincinnati Medical Center staff July 1, 1965, as director of Kettering Laboratory, center for research and graduate training in industrial and environmental health.

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## WHAT TO WRITE FOR:

**Cancer of the Lung and Reading on Cancer, an Annotated Bibliography:** These two new documents have been released by U. S. Public Health Service. "Cancer of the Lung" is a 10-page pamphlet which concerns itself with the diagnosis, treatment and prevention of lung cancer. It sells for 10 cents per copy. "Reading on Cancer, an Annotated Bibliography" has been prepared with teachers and students in mind but will also be of interest to the general physician. It sells for 15 cents per copy. Both pamphlets may be obtained from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

\* \* \*

**The Clinical Center: Current Clinical Studies and Patient Referral Procedures.** The Clinical Center of the National Institutes of Health at Bethesda, Maryland, is accepting a limited number of patients each month for study and therapy. Studies to which patients are currently being admitted and admitting procedures are described briefly in this brochure. Patients are admitted only on referral by a physician. Brochure is available, free of charge, from Department of Health, Education, and Welfare, U.S.P.H.S., National Institutes of Health, Bethesda, Maryland 20014.

\* \* \*

**The Beneficial Uses of Radiation Effects.** Report AD-601 493, prepared for the Air Force Materials Laboratory, Wright-Patterson Air Force Base, by the Radiation Effects Information Center at the Columbus Laboratories of Battelle Memorial Institute. May be obtained at 75 cents a copy from the Office of Technical Services, U. S. Department of Commerce, Washington, D. C. 20230; or through contractor channels from the Defense Documentation Center, Cameron Station, Alexandria, Va.

## COMING MEETINGS

### Ohio State Medical Association:

- 1965 Annual Meeting, Columbus, Week of May 9.
- 1966 Annual Meeting, Cleveland, Week of May 22.
- 1967 Annual Meeting, Columbus, Week of May 14.
- 1968 Annual Meeting, Cincinnati, Week of May 12.

### American Medical Association:

- 1965 Annual Convention, New York City, June 20 - 24.
- 1965 Clinical Convention, Philadelphia, Nov. 28-Dec. 1.

The American College of Physicians (Golden Anniversary Session), Conrad Hilton Hotel, Chicago, Illinois, March 22-26. For additional information write: Edward C. Rosenow, Jr., M. D., 4200 Pine Street, Philadelphia, Pa., 19104.

# Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee

Chairman, 2442 Dorman Dr., Portsmouth

MORE THAN TWO-THIRDS of the Auxiliary year has passed. It just doesn't seem possible! It might not be a bad idea at this point to remind the county auxiliaries that state and national dues should already be in the hands of Mrs. C. F. Goll, 1001 Granard Parkway, Steubenville. And that the names and addresses of delegates and alternates to the State Convention should, by now, have been sent to Mrs. Wallace Morton, 4153 Northmoor Road, Toledo. One other "deadline" bears reminder: Coming up is the county president's "narrative report" to the State President — Mrs. John D. Dickie (due March 1st), 2146 Shenandoah Road, Toledo, as well as all report forms to designated State Board members.

As has been the custom, a Certificate of Achievement will be awarded by the State Auxiliary at its May Convention in Columbus to each county achieving excellence in fulfilling the requirements established for 1964-65. Those counties which have done work beyond the set minimum requirements will be honored with gold seals on their certificates. Organized counties eligible for Certificates of Achievement are divided into seven membership groups and you should know where it is you "belong." Some months back, Mrs. C. H. Bell, Credits and Awards Chairman, sent you full information. If you feel a need to contact her, the address is 754 Dickson Parkway, Mansfield.

To refresh your memories, the priorities have been: AMA-ERF, membership, international health, program and legislation. Other suggested activities have included: community service, health careers, disaster preparedness, mental health, rural health, safety and any other community service project which has

met the needs of your community and been approved, of course, by your County Medical Society.

The requirements for Credits and Awards this year have been predicated on the program of our National President, Mrs. William H. Evans, of Youngstown, whose theme has been "Better Health — Better World."

## To Tuscarawas County — My Regrets

It is indeed unfortunate that Tuscarawas County Auxiliary with its full and outstanding schedule has not been mentioned before in this column this Auxiliary year. Mrs. Edward L. Miller of Dennison, publicity chairman, is not at fault, nor is your columnist. Somewhere along the line, material sent to me was lost. I am genuinely sorry. (And all the more chagrined because Mary Louise Van Epps, our State President-Elect, is from Tuscarawas County!)

A successful dinner meeting was held in September, I have discovered belatedly, and in October, Tuscarawas was hostess for the district meeting. In November, there was a stimulating and interesting session with one of the local doctors who had served on the *S. S. Hope*.

In December (the first month for which I have clippings) the Auxiliary members entertained their doctor-husbands with a Christmas party. Forty-nine members attended the festive occasion at the Reeves Motor Inn in New Philadelphia. Dr. and Mrs. Ben Pilloff of Canton were guests. Other honored persons included: Dr. Raymond Crawley, president of the Tuscarawas County Medical Society; Mrs. E. R. Hammersley, Auxiliary president; Dr. Sam Winston, incoming county medical president; Mrs. James Zeller, incoming auxiliary president; and

---

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*President-Elect:* Mrs. Herbert Van Epps  
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*Recording Secretary:* Mrs. M. W. Sloan, II  
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1001 Granard Pkwy., Steubenville



Mrs. H. F. Van Epps of Dover, president-elect of the State Auxiliary.

At this event, the Tuscarawas doctors made their annual contributions to AMA - ERF. The contributions were placed in a large red net Christmas stocking over which Mrs. R. A. Wilson, chairman, presided. A program of music by Mr. and Mrs. Dick Poletti provided the evening's entertainment.

Another Tuscarawas highlight in December was the autumn haze mink stole, valued at \$495, which was raffled off by the Auxiliary and won by Mrs. Emma Bonvecio of Wainwright. Proceeds from the sale of tickets will be used by the local group in its Health Careers and Nurses Loan Fund. Such funds, up to \$400, are available to a county graduate of either sex who needs financial assistance to further his or her education in any health-related field.

### Scioto County

The annual Christmas party of the Scioto County group was held, as it has been for many years, at the home of Dr. and Mrs. Clyde M. Fitch in the Rosemount area of Portsmouth. "Admission" was at least one toy for the Salvation Army Christmas Drive. There was the traditional Bake Sale which helps raise money for Health Careers and other special projects of Ways and Means. Mrs. Francis Kulcsar, president, announced that the usual Christmas baskets of fruit, candy, and tobacco were presented to the inmates of the County Home on behalf of the Auxiliary by Mrs. William Singleton. The speaker at the dessert luncheon was Mrs. Jane Mitendorf, chemist with Ashland Oil Company, who spoke on "Man Made Miracles" and demonstrated some of those miracles.

### Publicity Chairmen — Please!

There has been a woeful lack of clippings on county activities. Your reporter cannot record your many wonderful activities if she is not kept informed. Where, oh where, are all the local publicity chairmen? I should think that every local group would jump at the opportunity to see itself in print in the *Ohio State Medical Journal*. (C'mon, girls! Give yourselves a break — and me too!)

### Environmental Health Congress Scheduled April 26-27

Environmental influences from the ultravirus to the megalopolis and the manner in which they affect man, his health and well-being will be the subject of American Medical Association's Second Congress on Environmental Health Problems to be held April 26 - 27 at The Drake in Chicago.

The Congress, based on the theme "Population, Environment and Health," will explore population problems, changing environmental influences, changing disease patterns, control and prevention of disease and urban planning for healthful living.

## New Members...

Following are names of new members of the Ohio State Medical Association certified to the Columbus office during December. The list shows county in which new member is practicing or temporary address in the case of a physician taking graduate work.

### Cuyahoga

Jose M. Amodeo, Cleveland  
Ralph G. DePalma, Cleveland  
Charles M. Evarts, Cleveland  
Donald S. Gann, Cleveland  
John H. Gardner, III, Cleveland  
Sheldon J. Gillinov, Cleveland  
Clarence B. Hewitt, Cleveland  
William S. Kiser, Cleveland  
Millard Jensen, Northfield  
Mario A. Lacerna, Cleveland  
Javier Lopez, Cleveland

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### Starke

George R. Dakoske, Canton  
Raymond S. Rosedale, Jr., Canton

Dr. Austin S. Weisberger recently was appointed head of the Department of Medicine at the Western Reserve University School of Medicine and at University Hospitals of Cleveland.

The Fort Steuben Academy of Medicine had as guest speaker at its January 12 meeting Dr. R. D. Burk, director, Ohio Rehabilitation Center, University Health Center, Columbus. His topic was "The Injured Workman." The dinner meeting was held in the Fort Steuben Hotel, Steubenville.

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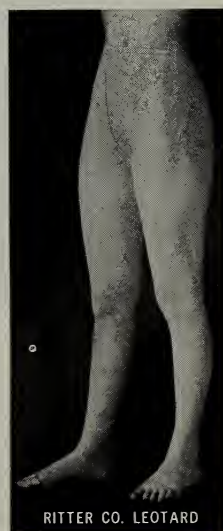
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2600 Union Central Bldg.

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**BROWN**—Carl A. Liebig, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown.

**BUTLER**—Marvin J. Rassell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton, 4th Wednesday.

**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond, 3rd Wednesday, monthly.

**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington, 4th Tuesday, 6 p.m., monthly, Clinton Memorial Hospital.

**HAMILTON**—John J. Cranley, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202, Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Walter Felson, President, 357 South St., Greenfield; Thomas Jones, Secretary, 528 South St., Greenfield, 1st Wednesday, every other month.

**WARREN**—Dale D. Hubbard, President, 116 Warren Ave., Franklin; D. Paul Ward, Secretary, Box 18, Pleasant Plain, 2nd Tuesday, monthly.

### Second District

Councilor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

**CHAMPAIGN**—Francis R. Grogan, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana, 2nd Wednesday, monthly.

**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield, 3rd Monday, monthly.

**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Bickenstaff, Secretary, 29 East Wood Street, Versailles, 3rd Tuesday, monthly.

**GRENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia, 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua, 1st Tuesday, monthly.

**MONTGOMERY**—Paul Troup, President, 2235 Philadelphia Dr., Dayton; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2, 1st Friday, monthly.

**PREBLE**—Willard C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

**SHELBY**—George J. Schroer, President, 322 Second Ave., Sidney; Alfonsas Kisielius, Secretary, Ohio Building, Sidney, 2nd Tuesday, monthly.

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Councilor: Frederick T. Merchant, Marion 43301  
1051 Harding Memorial Pky.

**ALLEN**—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima, 3rd Tuesday, monthly, except June, July and August.

**AUGLAIZE**—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville, Called meetings.

**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.

**HANCOCK**—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay, 3rd Tuesday, monthly.

**HARDIN**—Glen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center, 2nd Tuesday, monthly, except June, July and August.

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**MARION**—James A. McGlew, President, 399 E. Church St., Marion; Lester E. Wall, Secretary, 317 S. Main St., Marion, 1st Tuesday, monthly.

**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater, 3rd Thursday.

**SENECA**—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.

**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert, 4th Tuesday, monthly.

**WYANDOT**—Franklin M. Smith, President, E. Saffie Ave., Box 68, Sycamore; Robert E. Goyne, Secretary, 482 N. 7th St., Upper Sandusky, 2nd Tuesday, monthly.

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**FULTON**—Benjamin H. Reed, Jr., President, 101 Adrian St., Delta; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon, 2nd Tuesday, March, June, September and December.

**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon, 1st Tuesday, monthly.

**LUCAS**—Gordon M. Todd, President, 2005 Orchard Rd., Toledo 6; Mr. Robert W. Elwell, Executive Secretary, 3101 Colingwood Blvd., Toledo 10, 3rd Tuesday, monthly, except July and August.

**OTTAWA**—Robert Reeves, President, 118 Church St., Oak Harbor; Kenneth L. Akins, 208 W. Third St., Port Clinton, 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Laura at Merrin, Payne; Roy R. Miller, Secretary, 229 W. Perry St., Paulding. 3rd Wednesday, monthly.

**PUTNAM**—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Lugibihl, Secretary, Pandora. 1st Tuesday monthly.

**SANDUSKY**—Thaddeus Stabholz, President, 319 Birchard Ave., Fremont; John L. Zimmerman, Secretary, Memorial Hospital, Fremont. 3rd Wednesday, monthly.

**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

**WOOD**—Louis P. Baldoni, President, 138 E. Front St., Perrysburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

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10525 Carnegie Ave.

**ASHTABULA**—Harmon O. Tidd, President, 362 Rogers Place, Ashtabula; William F. Doran, Secretary, 241 Mill St., Conneaut. 2nd Tuesday, monthly.

**CUYAHOGA**—Middleton H. Lambright, Jr., President, 10616 Euclid Avenue, Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland, 6.

**GEAUGA**—Simon Ohanesian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

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438 North Park Ave.

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**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Kempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.

**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARK**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 44702. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

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Councilor: Benj. C. Diefenbach, Martins Ferry  
30 S. 4th St.

**BELMONT**—Robert N. Lewis, President, 100 W. Main Street, St. Clairsville; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.

**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.

**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

**MONROE**—Ronald E. Christman, Jr., President, 104 N. Sycamore St., Woodsfield; Byron Gillespie, Secretary, South Main St., Woodsfield.

**TUSCARAWAS**—C. Raymond Crawley, President, 232 West Third St., Dover; James R. Martin, Secretary, 404 N. Walnut St., Dover. 2nd Thursday, monthly.

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Councilor: Robert C. Beardsley, Zanesville  
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**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hoddsen, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Seneca; David O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.

**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

**NOBLE**—Frederick M. Cox, President, 1st National Bank Bldg., Caldwell; Edward G. Ditch, Secretary, Caldwell. 1st Tuesday, monthly.

**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.

**WASHINGTON**—Tuathal Patrick O'Maille, President, Marietta Memorial Hospital, Marietta; Richard R. Hille, Secretary, 323 Second St., Marietta.

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Councilor: George Newton Spears, Ironton  
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**GALLIA**—Isom C. Walker, Jr., M.D., President, Holzer Hospital, Gallipolis; Gene H. Abels, Secretary, Holzer Hospital, Gallipolis. Quarterly meetings.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

**JACKSON**—Carl J. Greever, President, 25 E. South St., Jackson; John E. MacLennan, Secretary, Oak Hill Hospital, Oak Hill. Called meetings.

**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

**MEIGS**—Selim J. Blazewicz, President, 112½ E. Main St., Pomeroy; Roger P. Danils, Secretary, Pomeroy. Called meetings.

**PIKE**—Kenneth A. Wilkinson, President, 330 E. North St., Waverly; Albert Shrader, Secretary, E. Water St., Waverly. 1st Tuesday, monthly.

**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

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Councilor: Richard L. Fulton, Columbus 43212  
1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

**FAYETTE**—Thomas J. Hancock, President, 220 E. Market St., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 2nd Friday, monthly.

**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

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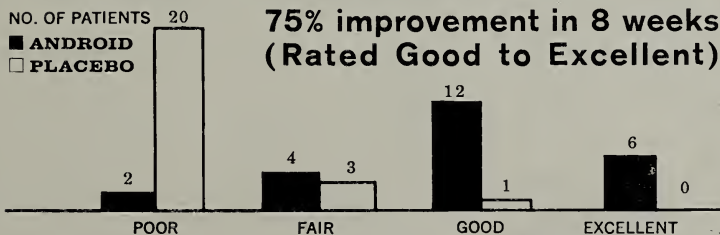
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2. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Inter-relationship.



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# Encephalitis in Ohio...

## State Health Director Issues a Warning That This Infectious Disease Is Reaching Serious Proportions

BECAUSE of its importance, the following information from the Ohio Department of Health is printed here just as it was released from the health director's office. *The Journal* has been informed that additional communications will be issued by the department as confirmations come from the Public Health Service Communicable Disease Center in Atlanta, or as the situation develops in this state.

\* \* \*

Dr. Emmett W. Arnold, Director of the Ohio Department of Health, recently released a report which indicates that infectious encephalitis is a growing problem in Ohio and may be reaching serious proportions.

He described encephalitis as a brain inflammation usually caused by some type of virus. It can be serious, causing death in some cases and leading to permanent brain damage in some cases. Many victims recover, however, without after-effects. The disease sometimes is popularly called "sleeping sickness" because of the coma into which many patients sink during the critical period of the illness.

During 1964, Dr. Arnold said 148 cases of encephalitis were reported to the Ohio Department of Health. The State Health Department, with cooperation of the United States Public Health Service, has been engaged in an epidemiological study of these cases. While the study is not yet completed, a preliminary report has revealed the presence of a previously unsuspected type of encephalitis in Ohio.

### California Type

This is known as California type encephalitis because it was first identified there. It has been reported in a number of other states, including Michigan, Wisconsin, Indiana, North Dakota and Florida.

The California type encephalitis is caused by a virus which is commonly transmitted by insects such as mosquitoes. The virus is known to occur in a number of small animals from which the mosquitoes can pick it up.

Blood samples from 10 of Ohio's encephalitis patients were put through exhaustive tests at the U. S. Public Health Service's Communicable Disease Center at Atlanta, Georgia, recently. Seven of the 10

showed signs of recent infection by the California group of encephalitis viruses.

The Ohio Department of Health has sent 80 more blood samples for examination at the CDC Center in Atlanta.

Preliminary review of Ohio's 148 reported encephalitis cases for 1964 shows only one of the St. Louis type which was responsible for outbreaks in several other parts of the country. The St. Louis type also is transmitted by mosquitoes. The only St. Louis type identified in Ohio occurred in Cincinnati. This patient died.

Another 45 encephalitis cases were determined to have been complications or "after effects" of such common viral infections as measles, mumps, chickenpox or influenza.

The remaining 102 cases, classed for the time being as non-specific, were the ones placed under study, Dr. Arnold explained.

"Discovery that seven out of the first 10 of these to be checked were of the California type means that we may be facing a serious problem," Dr. Arnold said. "Further spread of this illness by insects next summer is a serious possibility."

### Steps Being Taken

The State Health Director is taking several steps to meet this problem and proposing several others. These are:

(1) Local health officers throughout the state are being alerted.

(2) Private physicians are being notified to watch for signs of the illness.

(3) Plans are being made for a survey of small animals, both domestic and wild, which may be carrying the California type virus.

(4) Arrangements are being made for the trapping of insects which may be carriers of the virus.

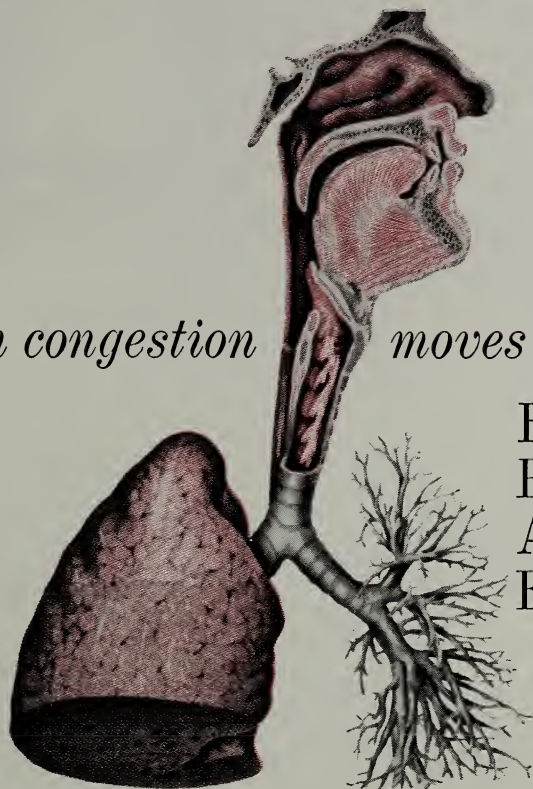
(5) Steps are being taken to expand the laboratory capacity of the State Health Department for improved surveillance. One of the State Health Department's top virologists is to take a special course on encephalitis detection offered by the United States Public Health Service.

"We know that we have a problem," Dr. Arnold said. "We know that it can be serious. Because



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it is primarily a summertime problem, when insects are prevalent, we have a few months to get ready for it. We're doing what we can."

He said that further studies this spring and summer may reveal the necessity for better insect control programs in some parts of the state.

An analysis of the seven cases of California type encephalitis already identified revealed several related factors. All were children, ranging in ages from six to 13. All had either slept in camps or in the open at home — where they probably were subject to insect bites. They came from widely distributed areas of the state. All have recovered from acute stages of the disease, but follow-up studies on them have not been completed.

---

### Adolescent Care, Subject at Ohio State Conference

The Ohio State University College of Medicine, Department of Pediatrics, Ohio Department of Health and the Columbus Children's Hospital announced the Sixth Annual Pediatric Postgraduate Conference to be held on March 31, April 1 and 2, at Children's Hospital, 561 South Seventeenth Street, Columbus.

This continuing education program with its distinguished guest faculty is designed to improve the understanding and the management of normal adolescents and common physical and emotional problems.

The course is planned especially for physicians; a limited number of nurses, psychologists and social workers concerned with the adolescent period will be admitted. In addition to the presentations by the faculty, there will be ample opportunity for discussion and question periods.

This program is acceptable for continuation study credit by the American Academy of General Practice.

The fee of \$60.00 will cover transportation costs from the motel to Children's Hospital, all coffee breaks, luncheon on Wednesday and Thursday and the Central Ohio Pediatric Society Dinner on Wednesday evening, March 31. Extra dinner reservations are available at \$5.00 each as indicated on the registration form.

\* \* \*

Other postgraduate courses of interest to physicians in connection with Ohio State University College of Medicine are the following:

March 17 — Course in Allergy

April 10 — Medical School Alumni Reunion

April 23, 24 — Anesthesia Course.

---

By invitation, Dr. Richard M. Hoar, associate professor of anatomy at the University of Cincinnati College of Medicine, conducted a symposium on experimental animal anesthesiology at the School of Aerospace Medicine, Brooks Air Force Base, Texas.

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## State Medical Board of Ohio Issues Annual Report

During 1964, the State Medical Board of Ohio through examination issued certificates to practice medicine and surgery to 362 graduates of schools of medicine. Dr. H. M. Platter, secretary, stated in the annual report of the Board.

Also 48 osteopathic applicants were successful and were issued certificates to practice osteopathic medicine and surgery. In the limited practice fields, 60 persons were issued certificates. Fifteen chiropodists (podiatrists) were issued certificates, and 22 physical therapists were licensed by examination.

By endorsement the Board issued certificates to practice to 516 medical applicants who had qualified in other states. Twenty-four applicants also qualified by endorsement for the practice of osteopathic medicine and surgery, and 36 physical therapists were also issued certificates by endorsement.

Investigators for the Board investigated 397 complaints of illegal practice. As many as 3276 calls were made in the various counties of the State in regard to investigations involving licensed as well as unlicensed practitioners. Six cases were filed in court; 17 cases were awaiting trial at the end of the year, and two persons were convicted.

\* \* \*

As a result of the examinations given December 17-19, certificates to practice medicine and surgery

in Ohio were authorized for 29 graduates of schools of medicine by the State Medical Board of Ohio, it was announced late in January.

Certificates also were authorized to 29 graduates of osteopathic schools to practice osteopathic medicine and surgery. One chiropodist (or podiatrist) will also receive a certificate.

In the limited practice branches, certificates were awarded in the following fields: 11 in physical therapy; 15 in mechanotherapy; 21 in chiropractic; 14 in massage, and 2 in cosmetic therapy.

## Million Given by Alumni For Medical Center

Alumni of the Health Science Schools of Western Reserve University have given \$1,007,170 to the development program of the University Medical Center.

This was announced by Charles B. Bolton, alumni chairman.

Graduates of the schools, including medical, dentistry and nursing, began their drive in January, 1963. They are seeking \$2.25 million as their share in the \$54.8 million medical center campaign. — *Cleveland Plain-Dealer*.

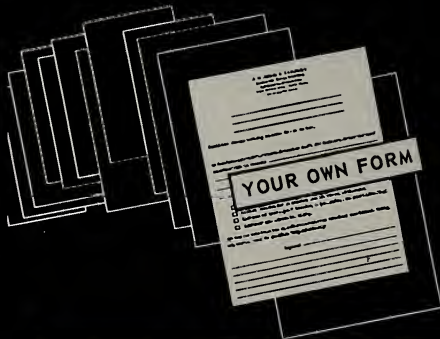
Dr. Harold R. Imbus, Marion, addressed the Galion Safety Council, discussing back ailments as related to industrial workers.

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# The Future of Anatomical Eponyms

GEORGE R. L. GAUGHRAN, PH. D.\*

IN 1945, F. Wood Jones wrote: "At no other time in its history has the science of human anatomy been in so great a danger of losing its best traditions as it is to-day."<sup>1</sup> Almost 20 years later we find that the International Committee on Anatomical Nomenclature has administered the *coup de grâce* to eponymous terms. Since this has happened within our time, let's review some of the events leading up to this unfortunate decision.

In 1887, at Leipzig, the Anatomische Gesellschaft set out to revise the entire anatomical nomenclature. Up to that time there had been little international agreement in terminology with a resulting duplicity of terms for the same structure; e.g., *valva coli* = *valva ileocecalis* = *valva Falloppiae*. The society appointed, in 1889, a commission of nine members to consider the names of structures in descriptive anatomy which can be seen with the naked eye or with the aid of a hand lens. After six years of work and a consideration of 30,000 terms, the committee made up a list of rules to be followed in anatomical nomenclature together with a list of about 5,000 standard terms. They decided that objective names should be given to all parts. However, because of lack of agreement, the descriptive term was to be followed, in brackets, by any widely used personal name.

## First International Congress of Anatomists

The committee's reasons for de-emphasizing eponyms were: (1) there were often historical injustices (names were not those of a real discoverer but rather a later observer), (2) different nations had different personal names for the same structure, and (3) many luminaries were not included as eponyms; but at the same time men of minor stature were eulogized. The first International Congress of Anatomists was held at Basle in 1895 and approved this nomenclature which they designated the B.N.A. (Basle Nomina Anatomica). The B.N.A. was adopted by the United States, Great Britain, Germany, and Italy—far short of international acceptance. During subsequent years, the stress of world friction and trauma of armed conflict prevented further meetings. Dur-

ing this hiatus, with little likelihood of an early meeting, the Anatomical Society of Great Britain and Ireland appointed a committee to consider a revision of anatomical nomenclature. In 1933 they published the Birmingham Revision of the Basle nomenclature (B.R.). Among other changes, the B.R. deleted all eponyms.

In 1935 the Anatomische Gesellschaft appointed a Nomenklatur Kommission to consider the original B.N.A. together with the British B.R. and to synthesize a terminology suitable to the German anatomist. In 1936 they published the Jena Nomina Anatomica (N.K. - J.N.A.) in the *Verhandlungen der Anatomische Gesellschaft*. Whereas earlier, eponyms were placed in brackets following the descriptive terms, they were now rejected completely.

During this period the American Association of Anatomists appointed a committee to study the confused state of anatomical terminology. A 57 page report, containing a modest revision of the B.N.A., was sent by this committee to the International Congress of Anatomists meeting at Milan in 1936. It was never published however and, apparently, had no influence on the use of the B.R. or J.N.A. In any case, the anatomists of this country decided that little of lasting value could be gained by setting up nationalistic terminologies and that we should continue to use the B.N.A. until, at some time in the future, an international meeting could be effected.

## Genesis of the Nomina Anatomica

After a latent period of 14 years the fifth International Congress met at Oxford in 1950. Here, at last, a nomenclature commission was reconstituted. This group formulated a set of general rules for terminology in addition to setting up the machinery for a detailed study of the B.N.A. The I.A.N.C. met in Paris in 1955 and again in New York City in 1960. These meetings produced the present Nomina Anatomica which has been presented in only one official publication by the Excerpta Medica Foundation.<sup>2</sup> One of the general principles presented is that eponyms shall not be used in the official nomenclature for gross or macroscopic anatomy. Most of our textbooks of gross human anatomy published since 1955 follow the N.A. and exclude eponyms completely. A few texts have introduced a glossary of

\*Dr. Gaughran, Columbus, is Associate Professor of Anatomy, and Vice Chairman, Department of Anatomy, The Ohio State University College of Medicine.

Submitted June 27, 1964.





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eponymous terms and one standard reference book has retained eponyms in parentheses.

Thus it is that our leaders in the field, men of vision, have failed to understand the past. During 1945 and 1946 a series of seven papers appeared in the *Anatomical Record* written by a group of Stanford University anatomists and dealing with various problems of terminology.<sup>3</sup> One of these reports contains the following: "An important advance made on the adoption of the B. N. A. was the omission of personal names except the small number retained in brackets. It is our opinion that the retention of these names in brackets has served no useful purpose and has probably been harmful on the whole." In reality the original B. N. A. contained only 105 different eponyms out of a total of 5600 terms. This represents less than 2 per cent. It is difficult to comprehend how these eponymous terms can serve no useful purpose, unless one has the narrowed viewpoint that everything one learns must have a utilitarian value.

Though we readily place the names of these early workers in potter's field, we do not hesitate to plagiarize their work. Consider but a few of the presently accepted terms such as process, eminence, and prominence. Does the student, or for that matter the instructor, distinguish between these terms? The names rectum, artery, bronchus, vibrissae, and pituitary, though of interest historically, are certainly not considered to be accurate, descriptive terms.

It is not the writer's purpose to unduly criticize the N. A. This revision is the result of the unselfish labors of some of our most learned scientists. However, with Sir Gordon-Taylor,<sup>4</sup> we too must register our "burning regret that eponyms have been so ruthlessly expunged from anatomical terminology." Bett,<sup>5</sup> in a study of eponyms, maintains that they are based on accidents and that they distort rather than commemorate the picture of earlier workers. One cannot deny that accident plays a role in the formation of eponyms as is true of history in general. Courses dealing with the history of anatomy are almost nonexistent, and history of medicine courses are approaching extinction. The distortion suggested by Bett is one of degree and hardly merits sacrificing one of the few remaining links between the student and his scientific heritage. Similarly, we must accept Hugh Barber's<sup>6</sup> castigation that eponyms have been used all too loosely with little thought of placing the man in proper context with his environment. This, however, is a criticism of the present-day worker and not the basic principle of eponymous nomenclature.

### Eponyms for the Curious Mind

Concerning eponyms, Kaplan<sup>7</sup> stated: "They not only are appropriate as instruments of precision, but serve to incite the curious and investigative mind to farther inquiry into original sources." Could it be that we are so busy pushing back the boundaries

of the unknown that we cannot take the time to learn what has been done in the past? Many investigations we undertake, if we search the literature with sufficient diligence, have already been answered. These early reports may appear in obscure journals or in a foreign language and need to be ferreted out. This is demanding of our time and should not be relegated to technician or laboratory assistant help. The past is neither dead nor useless—it breathes life into the present. How often have we asked ourselves: "Who was Glauber, or is it a place, or I wonder why they call it Bell's palsy?"<sup>8</sup> Is this time wasted which is required tracking down some of the history of eponymous terms? Each of us must supply his own answer. Be cautious, lest we find ourselves on the road to becoming educated illiterates.

The present writer feels as Doctor Herrlinger<sup>9</sup>: "... if here and there, through long decades of use, a name is related incorrectly with this or that investigator, this does not seem to be reason for rejecting the principle of eponyms; in by far the most cases, a deserved monument is established to important scholars through them." Recently, the writer became interested in the 'first rib shadow' as seen in chest x-rays. One of the structures suspected of causing this shadow is the suprapleural membrane (Sibson's fascia). In searching the literature no description of this structure by Francis Sibson was found. He did however, produce some very basic contributions to the study of respiration and comparative morphology of the respiratory muscles. Perhaps the greatest harm one might cause by retaining the form: suprapleural membrane (Sibson's fascia) is to stimulate the curiosity of the student to learn just a little bit about one of his predecessors who contributed in no slight fashion to the advancement of anatomy. Though the condensation and standardization of terminology is admirable, a dehydration and eponymous distillation leads to a tepid, insipid scientific jargon.

What about the future of anatomical eponyms? Can we, in fact, think in terms of the future since this form of anatomical canonization has been condemned to live in the past? The best we can hope for is that some among us will retain the eponymic name following the descriptive term. *Hic jacet* eponymy.

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# in peptic ulcer therapy—"little things mean a lot"

it's the sum total of many subtle advantages that makes glycopyrrolate a superior anticholinergic

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The remarkable efficacy of Robinul (glycopyrrolate) in the treatment of peptic ulcer cannot be attributed to any single characteristic of the drug. Rather it is the sum total of several subtle pharmacologic advantages that enables this anticholinergic to make such a significant contribution to the total ulcer regimen.

Epstein<sup>1</sup> found glycopyrrolate's intensive antisecretory action to be exemplary. Breidenbach<sup>2</sup> was impressed by its pronounced antispasmodic effects. And Young and Sun<sup>3</sup> reported that a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time. . . ." According to Slinger<sup>4</sup>, the absence of annoying side effects is an important plus factor ". . . for it permits ready individualization of dosage for control of mild to severe symptoms." Posey<sup>5</sup> sums it up when he says, "In effect, with glycopyrrolate, one approaches an ideal agent for the management of peptic ulcer. With it a vagolytic effect may be obtained without interfering with gastric emptying—the medical equivalent to vagectomy plus an adequate drainage procedure."

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## BRIEF SUMMARY

**INDICATIONS:** In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

**CONTRAINDICATIONS:** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

**PRECAUTIONS:** Administer with caution in the presence of incipient glaucoma.

**SIDE EFFECTS:** Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may

generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

**DOSAGE:** Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

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## Tremendous Results Witnessed Through Polio Vaccine

Without the Salk Vaccine which came into use in 1955, and the Sabin Vaccine of 1961, some 35,000 American children and adults might have been stricken by poliomyelitis last year, the Health Insurance Institute said recently.

At it turned out, 1964 marked the lowest point ever in polio incidence in the United States — only 121 reported cases. The year before that, 449 cases.

Moreover, there was no seasonal rise or noticeable "outbreak" in 1964. The year before there were eight outbreaks of paralytic polio. And the majority of cases in these outbreaks were among unvaccinated persons.

The Institute, reporting on its analysis of U.S. Public Health Service data, said that this infectious disease which often cripples or kills (8,822 deaths from 1952 through 1961) its victims, may be nearing the vanishing point in this country.

In any case, the success in arresting high polio incidence in the U.S., as well as many other countries, fixes the two vaccines as great victories for medical science ranking alongside the preventive measures used against cholera, smallpox, diphtheria, yellow fever, etc.

The effectiveness of the Salk Vaccine showed up dramatically after 1955, the year it was approved for

general use and then given widespread application. Polio incidence dropped from 28,985 in 1955 to nearly half that number the next year — 15,140.

By 1960, the year before the Sabin Vaccine came into use, the incidence had dipped to 3,190. In 1961 and 1962, cases numbered 1,312 and 910, respectively.

The annual incidence since 1960 is a far cry from the disease's peak years of 1949 when 42,033 were stricken; 1952, the worst polio year with 57,879 reported cases; and 1954 with 38,476 cases.

The Institute said that for the 10-year period of 1946-55, a total of 328,902 persons, mostly young people, were afflicted with polio. The yearly average — 32,890. Had the disease continued with its peculiar high but fluctuating incidence after 1955 without the medical arresting means of a vaccine, it is conceivable that somewhere between 30,000 and 40,000 persons a year might have been subsequently afflicted.

The Institute said its "projection" is based upon average incidence for the decade preceding the introduction of the Salk Vaccine.

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Dr. Rodney B. Hurl, Marysville, spoke on "Childhood Diseases" before the local Mothers' Club of Byhalia.

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Dr. Wayne W. Schroyer, of Ravenna, spoke before the Edinburg Elementary School Parent-Teacher Association, where he showed the film, "Valiant Heart."

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220





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## Snakebites in Ohio

HENRY M. PARRISH, M. D., DR. P. H.

MANY physicians practicing in the East North Central Region of the United States have not had extensive experience in treating victims of ophidian accidents (snakebites), which are medical emergencies requiring skillful management.

Ohio has the third highest incidence of poisonous snakebites of the states in the East North Central Region. The annual bite rates per 100,000 population for this region are: Indiana (0.97), Michigan (0.74), Ohio (0.46), Wisconsin (0.38), and Illinois (0.35). There were no snakebite deaths in Ohio during the ten year period, 1950-1959.<sup>1</sup> Almost nothing has been published about ophidian accidents in Ohio. It seemed worthwhile, therefore, to conduct a statewide survey for the following purposes: (1) to define the poisonous snakebite problem in Ohio as to time, place, activity, and person; (2) to relate some medical findings associated with these bites; and (3) to review, briefly, current concepts of snakebite treatment.

### Poisonous Snakes

According to Conant,<sup>2</sup> there are three species or subspecies of poisonous snakes indigenous to Ohio: the timber rattlesnake (*Crotalus horridus horridus*), the eastern massasauga or "swamp rattler" (*Sistrurus catenatus catenatus*), and the northern copperhead (*Agkistrodon contortrix mokeson*). Cottonmouth moccasins and coral snakes are not native to Ohio. The timber rattlesnake is the largest and most dangerous snake in the state. Bites by copperheads and

### The Author

● Dr. Parrish, Columbia, Missouri, is Associate Professor of Community Health, and Chief, Section on Community Health, University of Missouri School of Medicine.

massasaugas are much less lethal. See figure 1 for photographs of Ohio's poisonous snakes.

All of Ohio's poisonous snakes are pit vipers. They are so named because of a characteristic pit which is located between the eye and nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well-developed fangs, which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles, which are attached to their tails. Harmless snakes do not have facial pits, they have round rather than elliptical pupils, and, while they have teeth, they lack fangs.

Oftentimes people will chop off the head of a snake which has bitten someone and bring the snake's body in for identification. Pit vipers can be identified by turning the snake's belly upwards and noting a single row of subcaudal plates just below the anal plate. Harmless snakes have a double row of subcaudal plates. Figure 2 depicts the characteristic features of pit vipers and harmless snakes.

### Methods of Study

A questionnaire and a letter explaining the purpose of this study were mailed to a "selected" group of Ohio hospitals listed in the Guide Issue Hospitals (*Journal of the American Hospital Association*).

From the Department of Community Health and Medical Practice, School of Medicine, University of Missouri, Columbia, Missouri. Submitted July 10, 1964.

This investigation was supported in part by Public Health Service Research Grant GM 11268-02 from the Division of General Medical Sciences, U. S. Public Health Service.

The hospitals selected for this study were general hospitals, children's hospitals, and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force and Veterans Administration hospitals also were sent questionnaires. Maternity, tuberculosis, and mental hospitals were omitted as they would not be expected to treat snakebite victims. A total of 187 Ohio hospitals comprise the study group. Each hospital was requested to report all

in-patients treated for poisonous snakebites during 1958 and 1959. There were 20 cases in 1958 and 19 cases in 1959, an average of 19.5 cases per year. Of the 39 snakebites reported during 1958 and 1959, detailed case reports were received for 35 patients and only numbers of bites were reported for four cases. *All of the analyses in this paper, excluding the estimate of incidence, were based on the 35 detailed case reports received from hospitals.*

Physicians' reports, when adjusted to account for all Ohio physicians in the practice categories mentioned, indicated that approximately 24 in-patients and 21 out-patients were treated for snakebite accidents each year. The difference between the estimate of 24 in-patients treated by physicians and the average of 19.5 in-patients reported by hospitals can be explained, in part, by the following facts: (1) two counties from which physicians reported snakebites did not have hospitals listed in the Hospitals Guide Issue; and (2) there was evidence of under reporting snakebite in-patients from two hospitals which participated in the study. Taking all of these various reports into consideration, I estimate that approximately 45 (24 in-patients and 21 out-patients) people are treated annually for poisonous snakebites in Ohio. This provides an incidence of 0.46 bites per 100,000 population per year.

**Geopathology:** The geographical distribution of snakebites reported in Ohio during 1958 and 1959 may be seen in figure 3. The lightly shaded counties are those from which hospitals reported in-patients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten

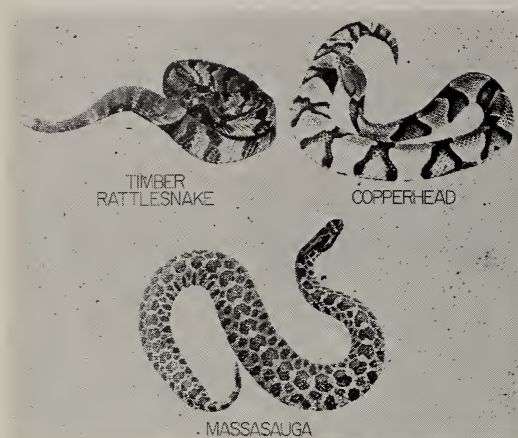


FIG. 1. *Poisonous Snakes Indigenous to Ohio.* (Photograph of massasauga courtesy of L. M. Klauber: *Rattlesnakes*. Berkeley, Calif., Univ. of California Press, 1956.)

in-patients admitted to the hospital for snakebite treatment during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and out-patient clinic visits. Since some snakebite victims are not admitted to the hospital as in-patients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an out-patient (office, home, emergency room, etc.) and on an in-patient basis. Previous surveys,<sup>3,4</sup> have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians, and orthopedic surgeons. Therefore, a random sample of one third of all the Ohio physicians in these categories of practice, who were listed in the *A. M. A. American Medical Directory*, were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the Ohio Department of Health.

## Results

This report is based on questionnaires returned by 187 (100 per cent) of 187 Ohio hospitals. It is supplemented by questionnaires returned by 1,415 (76 per cent) of 1,851 practicing physicians in the State. The Ohio Department of Health reported that there were no snakebite deaths during 1958 and 1959.

**Incidence:** Ohio hospitals reported a total of 39

## CHARACTERISTICS OF SNAKES

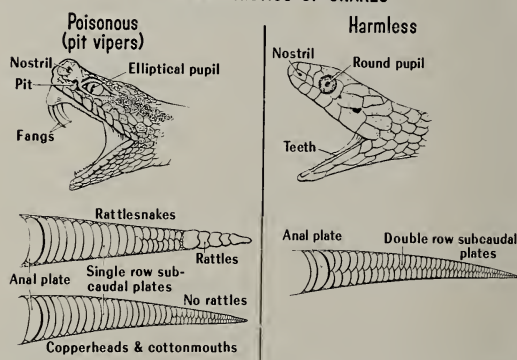


FIG. 2. *Characteristic Features of Poisonous (Pit Vipers) and Harmless Snakes.*

by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of 35 people hospitalized for snakebite treatment for whom detailed records were available, 21 (60 per cent) were bitten by copperheads, two (6 per



cent) by rattlesnakes, and 12 (34 per cent) by unidentified poisonous snakes. One rattlesnake bite was inflicted by a timber rattler and the other resulted from a massasauga bite. In addition, the four northernmost bites by unidentified poisonous snakes probably were inflicted by massasaugas since they are the only poisonous snakes found that far north.

Figure 3 shows that ophidian accidents were re-

**Temporal Relationships:** The monthly distribution of snakebite accidents is shown in Table 1. Snakebites were infrequent during the colder months of the year, November through April. In general, snakes are usually inactive and/or hibernating during the colder months. All of the snakebites in Ohio happened from May through October. This striking seasonal distribution of bites coincides with the time

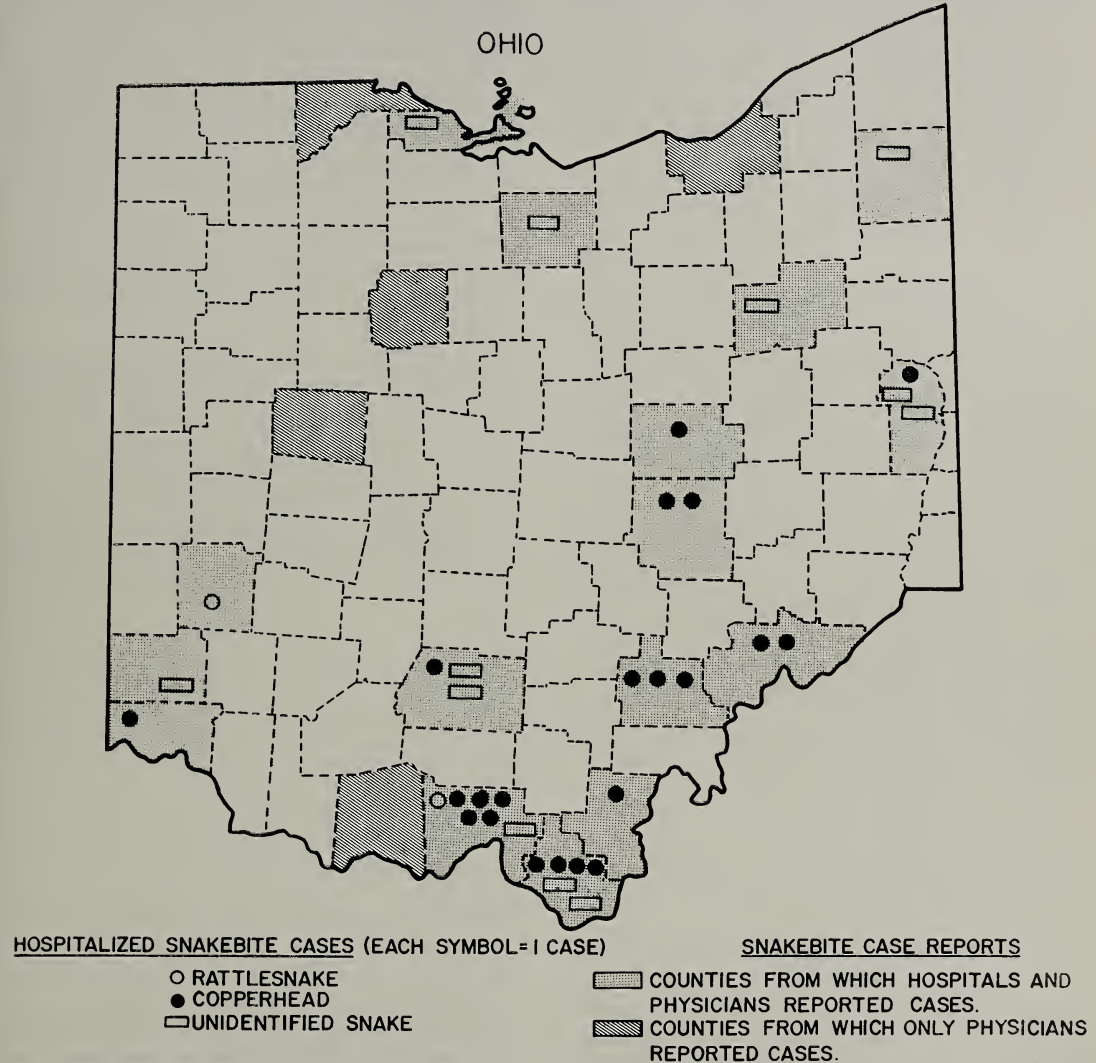


FIG. 3. Geographical Distribution of Ophidian Accidents in Ohio, 1958 and 1959.

ported from all sections of the state except the north-west corner. However, the largest number of bites, by far, occurred in the southern and eastern parts of Ohio. Copperhead bites were confined to the southern and southeastern parts of the State. These geographical patterns of bites by various kinds of snakes are consistent with the ecological ranges of snakes in Ohio described by Conant.<sup>2</sup>

that snakes are most abundant and active and with the time that people have greater exposure due to out-of-doors occupations and recreation. Similar "seasonal epidemics" of venomous snakebites have been observed in New England and North Carolina.<sup>3, 4</sup>

The time of day when most snakebite accidents happened was the six hour period from 6:00 to 11:59 p.m. when 19 (54 per cent) people were

bitten. The number of bites by three hour periods of time were: 6:00 to 8:59 a.m., no bites; 9:00 to 11:59 a.m., five bites; 12:00 noon to 2:59 p.m., six bites; 3:00 to 5:59 p.m., five bites; 6:00 to 8:59 p.m., 11 bites; and 9:00 to 11:59 p.m., eight bites. There were no bites from 12 midnight to 5:59 a.m.

**Bite Victims:** There were 23 white males, 11 white females, no nonwhite males and no nonwhite females admitted to Ohio hospitals for snakebite

TABLE 1. *Seasonal Distribution of Ophidian Accidents in Ohio, 1958 and 1959*

Month	No. Bites	Month	No. Bites
January	0	July	6
February	0	August	12
March	0	September	9
April	0	October	1
May	4	November	0
June	3	December	0

treatment during 1958 and 1959. The race and sex of one patient was not stated. Using the 1960 census for the population of Ohio the bite rates per 100,000 population were: 0.53 for white males, 0.0 for non-white males, 0.24 for white females and 0.0 for non-white females. Thus, males had higher snakebite rates than females and whites had higher rates than nonwhites.

The age distribution of Ohio bite victims is shown in Table 2. The largest number of bites happened to

TABLE 2. *Age Distribution of Hospitalized Snakebite Victims in Ohio, 1958 and 1959*

Age Group (years)	Population at Risk*	No. Bites	Rate per 100,000**
0 - 9	2,173,719	14	0.64
10 - 19	1,580,838	8	0.51
20 - 29	1,163,346	4	0.34
30 - 39	1,363,272	4	0.29
40 - 49	1,207,478	1	0.08
50 - 59	942,313	3	0.32
60 - 69	709,904	1	0.14
70 or more	565,527	0	0.00

\*Based on the 1960 Census of the Population of Ohio.  
\*\*These rates are only on hospitalized patients for whom information was available.

children and youths 0 - 9 years of age (14 bites) and those 10 - 19 years of age (eight bites). Indeed 63 per cent of all snakebites were inflicted on children and young adults less than 20 years of age. Age-specific bite rates are much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rates per 100,000 population were: 0 - 9 years of age (0.64) and 10 - 19 years of age (0.51). The lowest bite rates were found among people 70 or more years of age.

An analysis of the occupations of the patients showed that 22 were children, four were housewives, two were craftsmen, two were operatives, and one each was a professional, a farmer, a clerical worker,

a laborer other than a farm laborer, and an unemployed worker.

**Activity and Place:** Ten ophidian accidents occurred while children were playing, five in their own yards and five elsewhere. An additional five people were bitten while walking or working in their own yards. Six people were bitten while handling a poisonous snake, two while engaged in recreation other than hunting or fishing, one while picking berries, one while walking on or near a highway. The activity was not stated for the remaining patients.

The place where the bite accident happened is closely related to the activity when bitten. The largest number of snakebites, 10, happened right in patients' own yards. Three people were bitten in the woods, three inside houses while handling "pet" snakes, two in a field away from the house, and one each near a lake or body of water, on a farm not near the house and on or near a highway. The place where the ophidian accident took place was not coded for the remaining patients.

**Site and Severity:** The anatomical sites on human beings where venomous snakes inflicted their bites are shown in Table 3. Ninety-four per cent of the

TABLE 3. *Anatomical Sites of Bites by Poisonous Snakes in Ohio, 1958 and 1959*

Anatomical Site of Bite	Side of Body		Total No. of Bites
	Right	Left	
Head, face & neck	0	0	0
Trunk, front	0	0	0
Trunk, back	0	0	0
Upper arm	0	0	0
Forearm	0	0	0
Hand	3	0	3
Fingers	5	2	7
Upper leg	0	0	0
Lower leg & ankle	10	4	14
Foot	6	3	9
Toes	0	0	0
Not stated	—	—	2

bites were inflicted on the extremities, 28 per cent on the upper extremities and 66 per cent on the lower extremities. The fingers and hands were the parts most often bitten on the upper extremities. The feet and legs, including the ankles, were the parts most frequently bitten on the lower extremities. The site of the bite was not coded for two patients.

A modification of the clinical classification of pit viper venenation by Wood, Hoback and Green<sup>5</sup> was used to determine the severity of bites. Bites were classified as follows:

GRADE 0 — *No venenation.* Fang or tooth marks, minimal pain, less than 1 inch of surrounding edema and erythema. No systemic involvement.

GRADE I — *Minimal venenation.* Fang or tooth marks, severe pain, 1 to 5 inches of surrounding edema and erythema in first 12 hours after bite. No systemic involvement usually present.

GRADE II — *Moderate venenation.* Fang or tooth marks, severe pain, 6 to 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement



may be present—nausea, vomiting, giddiness, shock or neurotoxic symptoms.

**GRADE III—Severe venenation.** Fang or tooth marks, severe pain, more than 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for 31 hospitalized patients: eight (26 per cent) were Grade O; 13 (42 per cent) were Grade I; six (19 per cent) were Grade II; and four (13 per cent) were Grade III. For the remaining four hospitalized patients the severity of venenation was not stated. There were no deaths among the 35 hospitalized patients in this series. Furthermore, there were no deaths during 1958 and 1959 among the estimated 45 snakebite cases that occurred annually. The case-fatality rate for poisonous snakebites in Ohio is estimated to be less than one tenth of 1 per cent. This is confirmed by the fact that there have been no snakebite deaths in Ohio from 1950 through 1959.<sup>1</sup> The paradox of a moderately high incidence of poisonous snakebites with a low case-fatality rate in Ohio can be attributed to the high percentage of copperhead bites and the low percentage of rattlesnake bites, to the prompt availability of medical care, and to the effectiveness of snakebite therapy. Large rattlesnakes (*Crotalus sp.*) cause more deaths than any other poisonous snakes in the United States.<sup>6</sup> There were no deaths in the United States definitely attributed to copperheads from 1950 to 1959. This finding should not imply that copperhead bites are not occasionally serious or are not potentially lethal.

### Treatment

The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied to the involved extremity several inches proximal to the bite. The constricting band should be applied only tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation*, and it should be released every 10 to 15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction (I. S.) is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first-aid kits effective for removing pit viper venom. Incisions, one-quarter inch long and one-eighth to one-

quarter inch deep, are made into the subcutaneous tissues over the fang punctures. A few (3 to 5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to I.S., in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent® (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given. For Grade I venenations, antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000 cc. of normal saline may be given intravenously.<sup>7</sup> Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.<sup>8</sup> Injection of antivenin into the local bite area is not a particularly effective way to administer antivenin.

We have found the following amounts of antivenin useful in treating the various Grades of venenation: Grade O (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10 cc. (one ampoule) of antivenin; Grade II (moderate venenation) requires 30 to 40 cc. of antivenin; and Grade III (severe venenation) requires 50 cc. or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram-negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution, and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as packing an extremity in ice or using ethyl chloride.<sup>8</sup> In our opinion, cold therapy should not be used in treating pit viper bites.

### Summary

An estimated 45 (24 in-patients and 21 out-patients) people in Ohio were bitten by snakes

annually — an incidence of 0.46 bites per 100,000 people. However, the estimated case-fatality rate was less than one tenth of 1 per cent.

Of 35 in-patients reported in detail by Ohio hospitals during 1958 and 1959, 21 (60 per cent) were bitten by copperheads, two (6 per cent) by rattlesnakes, and 12 (34 per cent) by unidentified poisonous snakes. "Seasonal epidemics" of snakebites occurred with all of the bites inflicted from May through October.

Males had higher bite rates than females and whites had higher rates than nonwhites. Sixty-three per cent of the cases were among children and young adults less than 20 years of age. Ninety-four per cent of the bites were on the extremities — 28 per cent on the upper extremities and 66 per cent on

the lower extremities. Current snakebite treatment is discussed.

**Acknowledgment:** The author cites with gratitude the technical assistance of the following persons: Judi Pummill, Genevieve Calesibetta, and Linda Hinson.

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**ACUTE HEMATOGENOUS OSTEOMYELITIS.** — The surgical treatment of acute hematogenous osteomyelitis has changed little in the past 30 years. The better prognosis measured in mortality figures of from 20 to 40 per cent down to 1 to 2 per cent has rightly been attributed to the penicillin and supportive treatment in the septicemia phase. The advent of antibiotic treatment has made surgical judgment more difficult and complicated but no less important in reduction of disability and prevention of complications. The necessity for surgical intervention is indicated by the presence of a persistent abscess and should be done as soon as the diagnosis is reasonably certain and the patient's general condition is good. There appears to be no necessity for emergency surgery in the presence of obvious septicemia or severe toxemia, although aspiration to determine antibiotic sensitivity of the causative organism should be done immediately if the antibiotic treatment seems ineffective.

Systemic antibiotic therapy should be continued until all activity has apparently ceased. Repeated physical examinations help determine this. Operation for the removal of sequestra should be postponed until activity is at a minimum and should be done with a minimum of dissection of bone and soft tissue, and the wound should be closed primarily. Probably some sequestra may be safely left alone, although there is a case on record of a flare-up of osteomyelitis in an old sequestrum eight years after the disease had subsided without intervening signs or symptoms or activity. — William N. Harsha, M. D., Oklahoma City, Okla., *Southern Medical Journal*, 57:370-373 (April) 1964.

**RESPONSE TO CARDIAC PACEMAKER.** — It is suggested that potassium depletion may cause pacemaker failure. The oral administration of potassium is advised as a method of restoring myocardial responsiveness to a partially exhausted pacemaker until a replacement can be implanted. — Colonel Weldon J. Walker, M. C., USA, et al.: *The New England Journal of Medicine*, 271:597-601, Sept. 17, 1964.



# Correctable Renal Hypertension

## XII. Prognosis

CHESTER C. WINTER, M.D.\*

THERE are two basic questions concerning renal hypertension to which clinicians strive for answers. First, does the demonstration of a vascular or renal lesion mean that it has initiated blood pressure elevation? Second, if the first assumption is made, will correction of such a lesion result in a cure of the hypertension? In looking at the first question, we are becoming more satisfied that the mere demonstration of renal artery stenosis or unilateral kidney disease does not mean that it is the causative factor of associated hypertension. It is necessary to make a careful survey of several aspects of renal function in order to gather conclusive evidence that such a lesion is, in fact, instigating the series of events that produce renin and angiotensin.

The patient's history is important. Hypertension of short duration or of a benign character that suddenly accelerates tends to have a better outcome if a renal lesion is promptly demonstrated and remedied. Conversely, however, an exception is recorded of hypertension enduring for 10 to 15 years prior to the triumph of surgery.

The age of the patient appears to influence the prognosis of hypertension. Demonstrable renal lesions in individuals under the age of 40 enjoy a higher cure rate. In older age, elevated vascular pressure produced by similar lesions has not attained as high a rate of cure, apparently because of concurrent degenerative diseases some of which may involve the vascular system. In some reports the female sex appears to influence the outcome favorably, indicating that a hormonal factor may play a role in some types of renal hypertension.

The most important prognostic features appear to revolve around the individual and comparative kidney functions. Patients showing marked reduction in urine flow rate from an affected kidney have a higher curability. Also, if the urine on the involved side shows a greater concentration of solutes such as creatinine, urea, PAH, or osmolality, the prognostic value of the decreased urine flow rate is enhanced. The finding of marked dysfunction in one kidney with a contralateral state of normalcy is an excel-

lent set of circumstances from the prognostic standpoint. Normal total kidney function, determined by valuations of serum creatinine or renal clearance tests, are essential for a favorable postoperative course.

The radioisotope renogram, since it reflects vascular capacity, functional ability, and changes in urine flow rate, is likewise useful in comparing one kidney with its mate in respect to prognosis. Aortography is of predictive value when significant renal artery defects are outlined and when generalized vascular disease is present. Bilateral or multiple renal vascular lesions are less likely to result in a surgical cure even though all arteries are rehabilitated. Excretory urography is of prophetic value especially when one kidney shows a delay and initial decrease in concentration of contrast material and a later hyperconcentration of iodinated urine.

Some prediction designs are predicated upon the outcome of one or two kidney tests such as the urine flow rate, creatinine concentration, sodium concentration and PAH concentration. However, it would seem more profitable to evaluate all factors known to influence the prognosis. For example, a 48 year old woman who has had hypertension for less than one year with normal kidney function on one side, but a decreased flow rate, abnormal renogram, aortographic defect, and pyelographic dysfunction on the affected side, would most likely be cured by appropriate surgery. On the other hand, a 42 year old man with hypertension of 10 years duration, equal kidney function, slight bilateral changes in the renogram, an abnormality only on one side by aortography and excretory urogram, would not likely be cured by surgery. There is no foolproof scheme for choosing candidates for surgery or predicting curability at the present time. There is increasing indication that the bioassay of renin, renin-substrate, or angiotensin in peripheral or renal venous blood will predetermine the selection of patients for beneficial surgery. However, in chronic hypertension, other elements such as neurogenic or baroreceptor mechanisms may determine the patient's future.

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*Correctable Renal Hypertension*, Philadelphia, Lea and Febiger, 1964.

\*Dr. Winter, Columbus, is Professor of Surgery and Director of Division of Urology, The Ohio State University Hospitals.

# Carcinoma of the Ampulla of Vater

## Case Report of Treatment with Pancreaticoduodenectomy

JACK E. TETIRICK, M.D.\* and GAIL W. BURRIER, M.D.

THE gloomy attitude assumed by many physicians toward the value of surgery for malignant lesions of the pancreas is particularly harmful to the patient with carcinoma of the ampulla of Vater. Five-year survival rates of 36.3 per cent and 38.4 per cent following radical resection are reported for large series of these cases.<sup>1,2</sup> Reports of single cases and small series of cases are becoming common.<sup>3-17</sup>

The principles and technical methods used in surgery for these tumors have progressed from the pioneering effort of Whipple, through the contributions of Brunschwig, Child, Dennis, Varco, Cattell, Pearse and others to a well standardized procedure with an acceptable operative mortality.<sup>18-25</sup> The necessity of

### The Authors

- Dr. Tetirick, Columbus, is a member of the Attending Staffs, Riverside Methodist Hospital and Grant Hospital; Instructor, Department of Surgery, The Ohio State University College of Medicine.
- Dr. Burrier, Canal Winchester, is a member of the Active Staffs, Grant Hospital, and St. Ann's Hospital, Columbus.

nated except for unusually debilitated patients. Attempts to extend the operative procedure further by concomitant portal vein resection have been disappointing, and technical improvement seems to be reaching a point of diminishing return.<sup>26-27</sup> Liver metastases occur in 26 per cent and positive lymph nodes in 29.4 per cent of patients having surgery for these lesions.<sup>28</sup> The assumption is that considerable improvement in total salvage could be effected by a more vigorous effort at earlier tissue diagnosis in patients with jaundice. The following case report illustrates the value of early diagnosis and surgery.

### Case Report

A 73 year old school janitor was admitted to the hospital in September 1958 after an illness of two weeks' duration. The initial symptoms were anorexia and episodes of diarrhea. The patient then noted the onset of jaundice without pain, the passage of dark urine and light colored stool, and the onset of mild pruritus. Physical examination confirmed the presence of scleral icterus. No abdominal organs or masses were palpable. Rectal examination was negative, but the stool gave a 4 plus reaction to guaiac. The patient was referred to the hospital with a diagnosis of carcinoma of the ampulla of Vater with obstructive jaundice.

Laboratory studies revealed a hemoglobin of 13 Gm. per 100 ml., red blood cell count 4.15 million, white blood cell count 9,400 with a normal differential. The alkaline phosphatase was 6.35 units, direct van den Bergh 4.5 mg. per 100 ml., and indirect van den Bergh 7.0 mg. per 100 ml. The cephalin flocculation was negative, and the prothrombin time was 100 per cent. The electrocardiogram was normal except for occasional premature ventricular contractions and flat T waves in AVL, V<sub>5</sub> and V<sub>6</sub> interpreted as "ventricular strain" or digitalis effect. Gastrointestinal roentgenograms revealed a nonvisualizing gallbladder compressing the duodenum and nonspecific duodenal changes that were not diagnostic.

Surgery was performed one week after admission. The tumor was exposed by duodenotomy, and a frozen section diagnosis of adenocarcinoma of the ampulla of Vater was obtained. There were no metastases. A pancreaticodu-

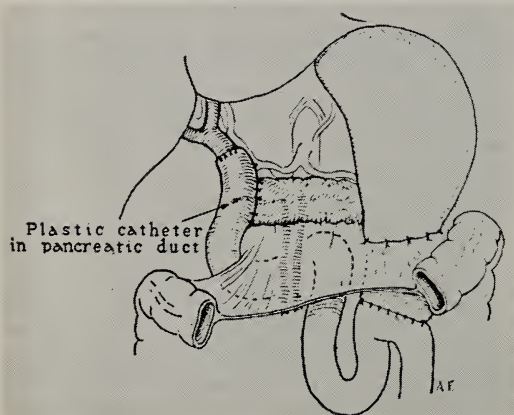


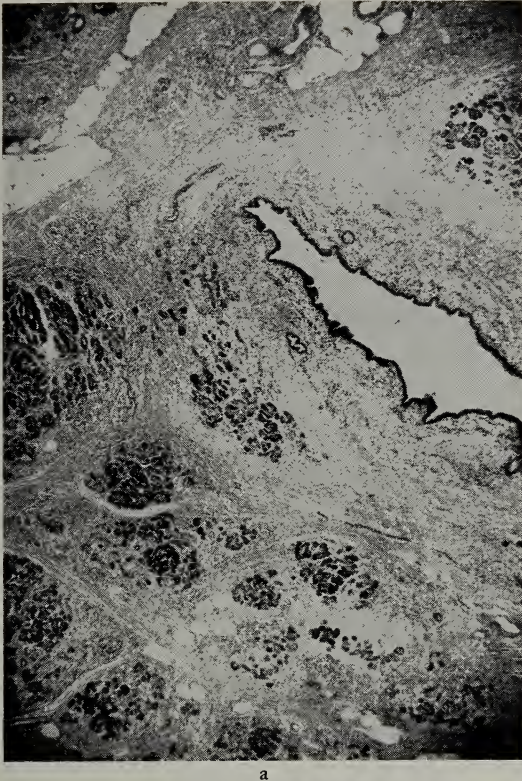
FIG. 1. Gastroenteric reconstruction following pancreaticoduodenectomy employing anastomosis between the end of the pancreatic duct and the side of the jejunum as well as end-to-end choledochojejunostomy. Note use of polyethylene catheter for pancreatic duct to jejunal mucosa anastomosis. (Reprinted by permission of the publisher from Porter, M. R.: *Ann. Surg.* 148:711, 1958.)

en-bloc resection for the patient has been proven by recurrence of tumor after local excision, with subsequent cure by radical pancreaticoduodenectomy.<sup>8</sup> "Conservative" local resections have therefore been abandoned. Staging of the resection has been elimi-

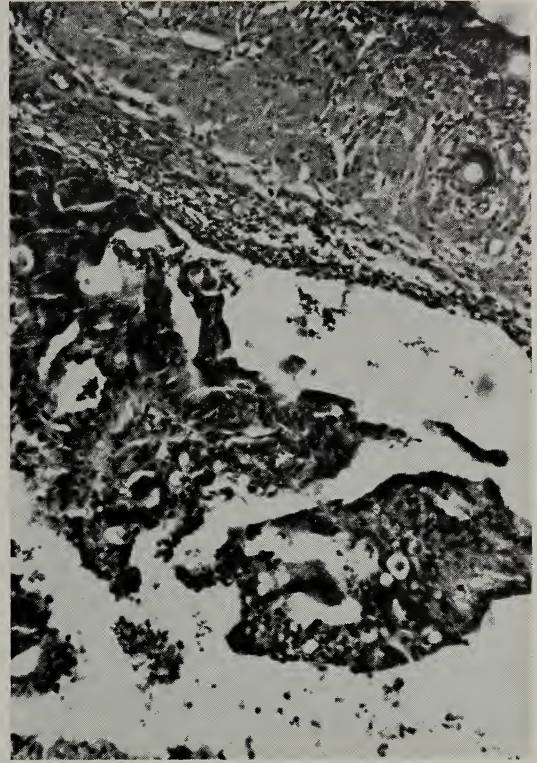
\*From the Surgical Service of Grant Hospital, 309 E. State Street, Columbus, Ohio. Submitted June 25, 1964.

\*Address requests for reprints to: Jack E. Tetirick, M.D., 131 South Grant Avenue, Columbus, Ohio 43215.





a



b

FIG. 2. Microscopic section of the tumor. Tissue diagnosis of adenocarcinoma of the ampulla of Vater. a. Ampulla with transition zone into tumor ( $\times 37.5$ ). b. Cell characteristics of tumor ( $\times 210$ ).

denectomy was performed with an end-to-end choledochojejunostomy, and an end-to-side pancreaticojejunostomy utilizing a small polyethylene catheter sutured into the pancreatic duct for the mucosa to duct anastomosis (see figure 1). The gastrojejunostomy was performed, and a draining jejunostomy tube was passed retrograde into the stomach prior to closure of the abdomen.

The patient had an afebrile postoperative course, the sutures and abdominal drain were removed on the eighth postoperative day. The patient then developed stomal obstruction, which required use of the draining jejunostomy for 10 days. The feeding jejunostomy was utilized between the fifth and sixteenth postoperative days. He was discharged on the twenty-first postoperative day.

The tumor was reported by the pathologist to be adenocarcinoma of the ampulla of Vater with obstruction of the common bile duct and pancreatic duct (see figure 2). Lymph nodes in the specimen did not contain metastatic tumor.

Since discharge the patient has had no major illnesses. He eats an unrestricted diet and has normal bowel function. He retired as janitor one year after surgery, at age 74, but continues to lead an active, normal life.

### Summary

A 73 year old patient with adenocarcinoma of the ampulla of Vater underwent pancreaticoduodenal resection five years ago and survives at present without evidence of recurrent disease and with entirely normal gastrointestinal function.

The evidence for curability of this tumor by surgery is reviewed. Increased total salvage of patients with this disease depends on aggressive management of jaundiced patients to secure an early tissue diagnosis.

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# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT G. THOMAS, M.D., *President*

## PRESENTATION OF CASE

A WHITE woman, aged 50 years, entered University Hospital with gangrene of the toes. She had had diabetes for nine years and had been treated first with protamine zinc and later with lente insulin. Three years prior to admission she developed ulcers on her lower extremities which healed with some difficulty, and four months prior to admission the toes of her right foot became discolored. Her family physician treated her with bed rest and vasodilators, with little improvement. In the past several weeks her right fourth toe had become black, and the patient also noted swelling and tenderness of the left calf.

### Physical Examination

On physical examination her blood pressure was 160/65, her pulse rate 90 per minute and regular, respiratory rate 22/min., and her temperature 98.6°F. The patient was obese and was complaining of pain in her left foot. Fundusoscopic examination revealed old exudates and arteriovenous nicking but no recent hemorrhages; microaneurysms were noted in the left eye. The heart and lungs were normal. The abdomen was obese and no masses were palpable. The left calf showed a 1.5 by 4 cm. firm tender mass. On the left ankle was an ulceration, and the left toes and the distal part of the foot were blue and black. There was a 3 to 4 cm. ulceration of the right buttock near the midline. Over the calf of the right leg was a 2 cm. ulceration. The fourth toe of the right foot was black and weeping. A bruit was heard over both femoral arteries; popliteal and dorsalis pedis pulses were not palpable. Neurological examination revealed decreased vibratory sensation in both ankle regions; deep tendon reflexes were 1 plus in the knees and ankles.

### Laboratory Studies

On admission her hemoglobin was 13.4 Gm., hematocrit 41 per cent; the white blood cell count was 9,380 with 78 per cent neutrophils. The urine had a specific gravity of 1.006; it contained no sugar or protein; there were 5 to 10 white blood cells per

## *Presented by*

- W. T. Carter, M.D., Columbus, and
- Emmerich von Haam, M.D., Columbus.
- R. G. Wieland, M.D., Moderator.

Edited by Dr. von Haam.

high power field. The fasting blood sugar was 129 mg. per 100 ml. The blood urea nitrogen, the CO<sub>2</sub> combining power, the sodium, potassium, chlorides, and total serum proteins were normal. The cholesterol was 173 mg. per 100 ml. with 64 per cent esters. The serologic tests for syphilis were non-reactive. Prothrombin time was 56.5 per cent. The alkaline phosphatase was 4.3 units, inorganic phosphorus 3.7 mg. per 100 ml. The total bilirubin was 0.4 mg. per 100 ml. Urinary 17-ketosteroid excretion was 1.7 mg. over 24 hours. A culture of the ulceration of the left calf produced a heavy growth of coagulase-positive Staphylococci. Chest x-rays showed only a slight plate-like atelectasis of the left lower lobe. X-rays of the feet showed generalized demineralization without evidence of any inflammatory destruction. An electrocardiogram was interpreted as normal.

### Hospital Course

On regular insulin and 40 units of lente her diabetes seemed relatively well controlled. She was treated with procaine penicillin at the time of admission but was later changed to Prostaphlin® when the organisms did not prove sensitive to penicillin. Warm soaks were applied to the lower extremities. The thrombophlebitis appeared to be superficial and the patient was not anticoagulated. Intermittently throughout her course the patient had postprandial nausea and vomiting and responded very poorly to Compazine®.

During the last four of the patient's 24 days in the hospital she showed increasing lethargy and her blood pressure dropped to 90/50; her pulse rate was 90 to 100, and her temperature spiked intermittently

Submitted December 21, 1964.

throughout the day to 101°F. rectally. Numerous cultures at this time were all negative. Her blood sugar was 214 mg. The patient became more difficult to arouse. Arterial gas studies revealed a low oxygen saturation at rest with a normal pH and CO<sub>2</sub>. During her last 48 hours her urinary output decreased and she became oliguric in the last 24 hours. On her last hospital day she was treated with Aramine®, chloromycetin, penicillin, and Solu-Cortef® but showed no response. Her pulse remained around 100 to 120, her blood pressure 60/30. Her temperature was 103°F. terminally. The patient died in shock.

#### CLINICAL DISCUSSION

DR. CARTER: This case is somewhat of a problem to me. I think, however, that it gives me the opportunity to discuss the differential diagnosis of peripheral vascular disease in a diabetic woman. The information we are given is probably adequate, although it is meager in some of the details we would like to know in dealing with a patient such as this. I would like to focus for just a bit on some of the things that we do know about her. We are told that she was diabetic and I would assume that this is true.

Three years prior to admission she began to develop ulcerations on her lower extremities and I consider this pertinent information because ulcerations on the legs are an uncommon finding as opposed to toe ulcerations in *arterial* disease of the lower extremities in the absence of either direct trauma or particularly a thermal injury. This, just on the surface at least, suggests that there was something else going on in this woman, perhaps involving the venous side of the circulation. Subsequently she developed ulcers of her toes and feet, which would be consistent with a severe degree of ischemic necrosis of both lower extremities, and at that time she was admitted to this hospital.

#### Intermittent Claudication

It is important, I think, to find out about location and duration of any claudication and the amount of activity that is necessary to bring it on. Obviously claudication in the thigh or in the hip is associated with occlusive disease at a higher level, and when we get claudication in the buttocks it is generally an indication of occlusive disease at about the level of the bifurcation of the aorta. We don't know whether or not this woman had claudication at any time. I would say it is probable that she did.

Her physical examination seemed to be consistent with her disease. We have an excellent description of her ulcerations but nothing really about the character of the skin that helps us tremendously in evaluating arterial disease in the lower extremities. We are told that she had a bruit over the femoral arteries. A bruit over the femoral or iliac arteries is invariably associated with either arteriosclerosis or atheromatosis of these vessels, and this certainly

would indicate that this woman had some interference with her vascular supply on an atheromatous basis. We are told that her popliteal pulses were absent. You would expect this woman with her evidence of vascular disease to have absent popliteal pulses. We are also told that her dorsalis pedis pulse was absent. This is probably a useless piece of information because the dorsalis pedis pulse is absent normally in 10 per cent of the population, while absence of a posterior tibial pulsation can invariably be considered as a sign of arterial insufficiency or arterial blockade.

Her ulcerations are quite consistent with the ischemic type of necrosis. The mass in her left calf would be taken as evidence of a superficial thrombophlebitis. Since this mass apparently did not pulsate or have a bruit we can exclude an arteriovenous fistula or a mycotic type of aneurysm. The presence of a superficial thrombophlebitis in arterial disease and in the absence of obvious cellulitis is a rather uncommon complication which is a bit disturbing for the evaluation of her primary disease. The presence of staphylococci in her ulcerations is about what I would expect. Other organisms can also be found depending upon how clean these ulcerations are kept. One may frequently find Clostridia infections, and I am surprised that the ulcers on her buttocks did not contain some Gram-negative rods since this would be an ideal place for coliform organisms.

She was treated and apparently was getting along reasonably well. They had no trouble in controlling the diabetes. Then something happened to her about four days before she died. We will come back to that in a few minutes.

#### Three Diseases?

Right now I would like to consider how I would put together the information that we are given. This woman perhaps had three types of peripheral vascular disease occurring simultaneously. The differential diagnosis of this vascular insufficiency of the lower extremities I think would fall between thromboangiitis obliterans and arteriosclerosis obliterans. Agewise this woman could reasonably be one or the other. The fact that she was diabetic would of course greatly favor the diagnosis of arteriosclerosis obliterans, but there are other characteristics that bother me in just accepting this as arteriosclerosis obliterans associated with atheromatous disease accelerated by the presence of diabetes. One of these is the presence of her superficial thrombophlebitis without evidence of cellulitis involving the area in this left calf.

Superficial thrombophlebitis is a much more common finding in thromboangiitis obliterans as opposed to arteriosclerosis obliterans. You get deep thrombophlebitis in arterial disease, but superficial thrombophlebitis is an extremely uncommon finding except in the individuals who get an extended cellulitis. Her age would help little in the differential diagnosis. Usually one would expect to see thromboangiitis



obliterans before the age of 40 and arteriosclerosis obliterans after the age of 50; between 40 and 50 it is sort of a toss-up. We are told that this woman had a normal cholesterol. This would favor thromboangiitis obliterans because we rarely see elevated cholesterol in this particular disease entity, whereas at least half the people with arteriosclerosis obliterans will have elevated cholesterol levels.

The presence of a bruit in the femoral artery would certainly again favor arteriosclerosis obliterans and one would not expect to hear them at all in thromboangiitis. The diminished popliteal pulses again would be in favor of an arteriosclerosis obliterans but it can also occur in thromboangiitis, and there are reasons to question whether or not the popliteal pulses were actually present. I therefore think there is some reason against accepting this involvement of the lower extremities solely as arteriosclerosis obliterans and atheromatous disease associated with diabetes.

Let us turn then for a minute and consider what factor came into play as the immediate cause of her death. In an individual who has ulcerations that are infected one might think of septicemia as the cause of death. Actually septicemia in ischemic ulceration is really a rare complication and it usually does not occur unless the lesions have been manipulated surgically. The sudden drop in her blood pressure would certainly go along with the Gram-negative type of infection. She obviously had many portals of entry; particularly this ulceration that was described on the buttocks could have been one. However, I think that her normal blood pressure and CO<sub>2</sub> combining power would be an unlikely finding in the presence of a Gram-negative septicemia with endotoxic shock since almost all of these patients are hypotensive and acidotic.

We are also told that this woman had postprandial nausea. How could this be related to her over-all disease and perhaps her death. She was not uremic and as best we can tell she doesn't have any disease in her biliary tract. So I would suggest the presence of an occlusion of the superior mesenteric artery due to acute thrombosis. We know that in vascular disease involving the celiac axis or the superior mesenteric artery postprandial nausea, vomiting and discomfort are quite common and often represent the only symptoms that these people have. This is certainly not an uncommon finding in a diabetic patient who already had evidence of atheromatous disease.

So I would consider her as a woman who although diabetic had a little different type of vascular disease than arteriosclerosis obliterans and atheromatous disease. I would say that she probably had thromboangiitis obliterans, arteriosclerosis obliterans, and lastly I think an occlusion of the superior mesenteric artery with infarction of the bowel which precipitated her death. We have a lot of other things to consider in this particular patient. I am sure that the thought of pulmonary embolization must have gone through the

minds of the house staff. We are told nothing about electrocardiograms or chest x-rays. The limited x-rays again are helpful in supporting my diagnosis of thromboangiitis obliterans since the x-rays of the feet at least do not show calcification of the vessels. Dr. Dunbar, would you like to comment on the x-rays that we have?

DR. DUNBAR: She has generalized osteoporosis and very minimal destruction of the terminal phalanx of the fourth toe on each foot. The chest is essentially normal except for some streaks of atelectasis in her lungs. I don't see any evidence of arterial calcification anywhere.

DR. CARTER: I think then that I would summarize this case by saying that this was a patient with thromboangiitis obliterans who happened to be diabetic and had some large vessel disease on an atheromatous basis. She died acutely because of occlusion of the superior mesenteric artery. I had intended to spend a little time talking about the contribution of Compazine to her death but because of time limitations I let this go.

### General Clinical Discussion

DR. WIELAND: There are certainly several possibilities that come to our mind other than those Dr. Carter mentioned. He mentioned one possibility—repeated pulmonary emboli—and I think we could have obtained more information as to whether indeed this was going on or not. I think the other thing is the question of why her urinary 17-ketosteroids were so low. I wonder, Bill, whether you would like to say why you did not mention these two possibilities?

DR. CARTER: I do pay attention to the vomiting but I don't pay too much attention to the 17-ketosteroids in a woman. They don't tell me anything about her adrenal function. Embolization in this type of patient would be an unusual type of complication. Terminally, she had a little hypoxia but this doesn't mean much with no other findings. If she had pulmonary embolization I would expect to see some alteration of her blood pH and CO<sub>2</sub>.

DR. WIELAND: I would like to question Dr. Saslaw about the use of antibiotics in ischemic disease. Do you feel they are of value or do you feel that they might have set the stage for a more serious type of infection?

DR. SASLAW: I think the selection of antibiotics is important and unless there is complete loss of circulation you will get some penetration.

DR. WARREN: I think that Dr. Carter is really on tenuous ground in making a diagnosis of thromboangiitis obliterans in a 50 year old woman who has diabetes and therefore is prone to atherosclerosis or arteriosclerosis, and who has an infection with cellulitis. The fact that you don't see calcification in vessels really doesn't hold a great deal of water be-

cause many patients with arteriosclerosis, especially of the small vessels, do not show any calcifications.

DR. GWINUP: The calcifications in the arteries below the knee in diabetes are calcifications of the media and they correlate very poorly with atherosclerosis. Of all the kinds of vascular disease mentioned I think this woman had widespread atherosclerosis. I also think that she certainly had the small blood vessel disease that diabetics *always* have and which was visualized in her retina.

DR. CARTER: You are talking about the ischemic neuropathy in the small vessel disease of diabetics but this is not the same thing as the big vessel disease that they get which is associated with loss of pulses.

DR. GWINUP: That is right. I think she had both diseases: I think she had atherosclerosis and she certainly had diabetic angiopathy.

DR. WIELAND: What do you think about the possibility that she had Addison's disease?

DR. GWINUP: The only thing you have to go on is one low 17-ketosteroid determination in her urine.

DR. WIELAND: You also have vomiting, fever and hypotension.

DR. GWINUP: Right. She died in shock and she was given corticosteroids, which incidentally did not seem to help her. She probably had no clinical evidence of long-standing adrenal deficiency, such as pigmentation and hypotension. So I wouldn't put too much emphasis on this although it could be an important clue.

DR. WIELAND: Certainly steroids do more than just maintain electrolytes or glucose concentration. The only point I was trying to make is that when you get a 17-ketosteroid of 1.7 in somebody that was dying for 72 hours there is no way of excluding the diagnosis of adrenal insufficiency.

DR. SASLAW: I wonder if we could give Dr. Carter a minute to talk about Compazine?

DR. CARTER: Compazine, like any of the phenothiazine-like drugs, can do strange things, and most people have the feeling that because we use them in such large doses in the emotionally disturbed patient this means that they are pretty benign. We don't know how much Compazine this woman got but it sounds to me as though the boys were going after her pretty vigorously. The drug tends to accumulate in the body and one would get a precipitous fall in blood pressure which is perfectly consistent with the findings in this patient. Unlike many situations of hypotension the hypotension produced by the phenothiazines is vasopressor-unresponsive. Instead of getting a rise in blood pressure you may even get a paradoxical further lowering of blood pressure, and this woman, for example, who had been

on Compazine therapy was given some vasopressor, which had no effect. This would be perfectly consistent with a hypotension associated with phenothiazine administration.

#### CLINICAL DIAGNOSIS

1. Thromboangiitis obliterans with gangrene of feet.
2. Generalized arteriosclerosis with thrombosis of superior mesenteric artery.
3. Diabetes mellitus.

#### PATHOLOGIC DIAGNOSIS

1. Generalized arteriosclerosis with thrombosis of aorta.
2. Bilateral massive adrenal hemorrhage with acute adrenal insufficiency.
3. Diabetes mellitus.

#### DISCUSSION OF PATHOLOGY

DR. VON HAAM: The patient was extremely obese and weighed approximately 225 lbs. The fourth toe on the right foot was gangrenous and the right lower leg showed ulcers covered with necrotic material. There was also a 2 cm. necrotic ulcer on the left leg. Her heart weighed only 350 Gm. and showed only slight muscular hypertrophy on microscopic examination. Her lungs showed congestion and hemorrhage with organized thrombi in many of the smaller vessels. The spleen was enlarged and showed evidence of extramedullary hematopoiesis microscopically. Her liver was large and showed severe fatty metamorphosis. The pancreas also was heavily infiltrated with fatty tissue and all the island cells could be identified. The gallbladder contained stones.

Both adrenals were markedly enlarged, weighing 30 Gm. each. Both showed a massive medullary hemorrhage which nearly destroyed the entire organ. The kidneys did not reveal any diabetic nephropathy. The vessels at the base of the brain were slightly sclerosed. The pituitary weighed 600 mg. and appeared normal grossly. Section of the pituitary showed cytologic evidence of hyperpituitarism. Most of the pituitary cells belonged either to the basophilic or the eosinophilic groups and only relatively few chromophobe cells were observed.

So we have then a patient with obesity, evidence of hyperpituitarism, diabetes, and generalized arteriosclerosis. She died from acute adrenal insufficiency caused by bilateral adrenal apoplexy. From the literature we know that about 25 cases of massive adrenal gland infarction have been reported in adults which was not due to the Waterhouse-Friderichsen syndrome or neoplasm. There was a variety of conditions which were blamed for this infarction — toxemia of pregnancy, insulin shock, and cortisone therapy. I believe that the low urinary ketosteroids and her sudden and severe hypotension were the two important clues for the clinical recognition of this lesion.



# Maternal Deaths Involving Lower Nephron Nephrosis

By the OSMA COMMITTEE ON MATERNAL HEALTH

## With Comment of Consulting Obstetrician and Gynecologist

**H**EMMORHAGE is still a prevalent cause of maternal deaths in Ohio, as shown by the seven consecutive annual reports rendered by the OSMA Committee on Maternal Health.

Although the majority of these maternal deaths occur within the first 24 hours from the direct results of the hemorrhage (uterine atony, abruptio placenta, etc.), a considerable number of women die in a week or more *after* the hemorrhage, from factors directly due to *transfusions* employed to save the patient's life during the initial hemorrhage. In this article the Committee presents three cases, maternal deaths due to the transfusion of whole blood: e. g., lower nephron nephrosis.

### Case No. 423

The patient was a 37 year old, white, Para II, cesarean II, who died 14 days postcesarean section. Her past history was noncontributory with a thyroidectomy in 1953. In the obstetric history she had had three previous pregnancies, the first two delivered at term with no known complications. However, the third pregnancy was complicated by severe antepartum hemorrhage (abruptio) in the 37th week. A primary classical cesarean section was performed delivering a living baby; details concerning amount of blood loss, transfusions, etc., are not available. With a last menstrual period on September 30, the patient registered in her fourth month and made nine prenatal visits. Her blood type was B-negative; serologic test for syphilis was negative. Additional laboratory studies are not listed. Followed by her physician (in the first county) she developed severe mental depression and threatened to commit suicide; however, she improved under therapy. On June 19 (34 weeks) she submitted to an elective repeat cesarean section performed under Pentothal® anesthesia; a living baby was delivered, but *excessive* bleeding was recorded during the operation. Two and a half units of B-positive blood were administered (although the patient's blood was B-negative). Bleeding continued; the patient received 5 more units of blood, plus parenteral fluids, to a total of 8000 cc.

Acute pulmonary edema developed, responding temporarily to oxygen and digitalization. During June 19, the output of urine was 125 cc. Three days later, in spite of treatment, the patient became anuric and was transferred to another (larger) hospital (in another county). Innumerable laboratory studies were performed; the patient was

never considered suitable for dialysis. Congestive failure continued. Mucosal hemorrhage appeared as the patient pursued a downhill clinical course. Anuria persisted and the patient died 20 days postcesarean section.

*Cause of Death (Autopsy):* Bilateral, acute, bronchopneumonia; fibrinous pleuritis, left; acute hemorrhagic gastroenteritis, uremia; hemorrhagic cystitis; lower nephron nephrosis.

### Comment

The Committee reviewed facts available in the case noting that certain details were not available. Members could only guess whether the first 2½ units of blood were administered in a desperate attempt to replace blood loss, or whether the B-positive blood was administered through laboratory error, or both! Members wondered (if the first were true) why plasma expanders were not administered while a careful recheck of the blood was being made. Or, better yet, was prophylactic blood prepared for administration *prior* to surgery? The question of a possible anemia existing in late pregnancy was also entertained. Based upon information available, the Committee voted this a preventable maternal death.

### Case No. 387

The patient was a 31 year old, white, Para IV, abortus I, who died 20 days postabortal. Originally the patient aborted in an adjacent state, hence, details in her case are lacking. Nothing is known of her past history except that she had four children born alive. Her last menstrual period is said to have been November 23. There were recurrent episodes of vaginal bleeding, the patient aborted, and a dilatation and curettement was performed March 29, during severe hemorrhage, in an adjacent state. Two units of blood were administered during the operation; the blood was said to have been routinely typed and crossmatched.

March 29, a renal shutdown occurred. Uremia developed. April 1, the patient was transferred to a large (Ohio) hospital where dialysis was performed twice. In spite of supportive treatment, the patient died April 18.

*Cause of Death (Coroner's Autopsy):* "Tubulorhectic" nephrosis (lower nephron nephrosis) due to blood transfusion reaction (anti-Kell); uremia; "Renal failure, with uremia, acidosis, electrolyte imbalance, apparently secondary to incompatibility of transfused blood." Status postabortal 18 weeks gestation.

### Comment

The Committee voted this a preventable maternal death. Members felt hampered by a lack of more avail-

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

able information concerning the patient's initial hospitalization (another state). Whether the patient was sensitized early, or whether a total laboratory error caused the renal shutdown remains an unsolved problem.

#### Case No. 437

This patient was a 31 year old, white, Para IV, cesarean II, who died nine days postcesarean section. Beyond a cholecystectomy performed in 1953, the past history was negative. The patient had four vaginal term deliveries supposedly without difficulty. In 1954 because of antenatal hemorrhage (previa) a cesarean section was performed; it is not known whether or not transfusions were given then. Little information is available concerning her prenatal course and care during the last (6th) pregnancy; her blood was AB-positive.

On August 26, (near term) the patient submitted to a repeat, elective, classical cesarean section, during which a living baby was delivered. Excessive bleeding appeared. Two units of AB-positive blood were given, following which the patient developed renal shutdown and uremia. Two additional units of blood were given August 30, one AB-positive, one A-positive. All four units were reported "compatible" but the technique of crossmatch was not stated. Pneumonia developed.

September 2, the patient was transferred to the second hospital where she received parenteral Chloromycetin®; a tracheotomy was performed. The blood urea nitrogen was 237 mg. per 100 ml. She was transferred to the third hospital for the artificial kidney September 4, but died before it was ready.

*Cause of Death (Autopsy):* Bronchopneumonia and septicemia due to hemolytic streptococcus, staphylococcus (mannitol and coagulase positive); acute tubular necrosis, due to transfusion reaction.

#### Comment

The Committee studied this case with great interest. Additional facts, explained in details of the pathologist's report, are quoted for information: "NOTE: The patient was sensitized to Rh c, E, and Kell (1:16) (1:28). Direct Coombs positive, indirect Coombs 1 plus. Rh c and E should be picked up on a routine high protein crossmatch. However, Kell is picked up only on indirect Coombs crossmatch.

"The patient had a 1 plus indirect Coombs test which means she was previously sensitized to the minor factors possibly at time of cholecystectomy in 1953 or cesarean section in 1954.

"Since this was an elective, repeat cesarean section, there was ample time to do an indirect Coombs crossmatch and this would have picked up the incompatibility and prevented the transfusion reaction."

After prolonged discussion, the Committee voted this a preventable maternal death.

#### Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was furnished at the request of the Committee:

"A great deal of progress has been made through excellent hematology research in the past decade. The close coordination of efforts in this progress between hematologist, OB-Gyn specialist, and internist have reaped many rewarding benefits toward ideal care of the obstetric patient.

"Today physicians are more aware of the *immediate* and *remote* tragedies associated with acute obstetric

hemorrhage. In the former, he faces a desperate situation in which he must act promptly, even with heroic treatment, viz, blood replacement until he secures avenues of hemorrhage in the bleeding patient. It is ironic that in this effort he occasionally becomes "trapped," for the very life-saving measure he utilizes to save the patient from *immediate* death, eventually causes a tragic systemic reaction in the patient, with a *remote* catastrophe, renal shutdown!

"It is obvious that the physician must anticipate these disasters, and (with the aid of the modern laboratory) he must prevent the immediate disaster, yet obviate the remote one.

"A few measures for prevention come to the pen of the writer at this moment: (1) Elicit any history of 'bleeding' or hemorrhagic episodes, early in the prenatal course — 'tag' her chart! (2) Always check the patient's hemoglobin and hematocrit at the 36th week of gestation, or immediately upon her initial admission to the hospital. (3) In the face of a low hemoglobin and hematocrit, have blood ready, properly typed and crossmatched, for any emergency. (4) Always have a supply of *correct* blood on hand for elective surgery. (5) Blood substitutes, or plasma expanders should be used in the face of acute hemorrhage, until whole blood is ready for transfusion. (6) Remember, there is a 'consoling' lag or period of time (laboratory reports indicating deficiency) between the initial massive hemorrhage, and profound shock. Anticipate the shock; have blood prepared.

"Case No. 423. In this case the error or omission is obvious, and should be carefully avoided.

"Case No. 387. The technical error apparently was in the laboratory although the immediate need for the blood cannot be ascertained from the scant information available.

"Case No. 437. Here the technical ramifications provoke the intrigue and amazement of the average obstetrician.

"The Consultant would choose to vote this case *preventable* (P<sub>3</sub>) on basis of a complex laboratory technicality. It is doubtful that prenatal tests including a battery of laboratory studies would detect this rather unusual incompatibility. However, as the facts develop, the case represents a preventable maternal death.

"To this consultant it is impressed once again, that the integrity of *your* laboratory is a sheet anchor upon which you must rely, especially for hematology and blood therapy. Once reliability is established, you may proceed with less reluctance to prescribe blood therapy, when it is indicated.

"In the desperation of a real emergency, all of us are naturally tempted to replace blood loss, in an endeavor to save the life of a patient. However, as alert, modern physicians, we must never ignore the potential hazards involved in the administration of a life-giving substance — blood."



# Vocational Rehabilitation And the Doctor

OSCAR L. CODDINGTON, M.D.,\* and JAMES W. McDANIEL, Ph.D.\*\*

AS A BY-PRODUCT of progress in medicine we can expect ever increasing numbers of persons who, were it not for the interference of well meaning physicians, would not survive. These together with the end results of various traumatic experiences constitute a group of handicapped individuals who, if not referred to the proper agencies, are likely to become a burden to society and will of necessity add to our continually increasing tax burden. However, this should not be the case. Many of these people, if properly handled, can not only be made self-supporting, but can become taxpayers instead of tax-consumers and may hopefully participate in reducing rather than raising taxes.

In this state, the Ohio Bureau of Vocational Rehabilitation, an arm of the State Board of Education, is the State agency designated by law to vocationally rehabilitate those individuals, other than the blind, who have a physical disability, mental illness, or mental retardation, which handicaps them in such a way that without guidance, physical restoration, or special training or education they will be unable to make their own way.

Although the medical profession is intimately involved with the handicapped, Table 1 shows the low percentage of clients referred by physicians to the Bureau of Vocational Rehabilitation.

TABLE 1. Percentages of Rehabilitated Cases Referred by Physicians, 1959 - 1963

	1959	1960	1961	1962	1963
United States ..... (Av. of 54 Agencies)	15.2	14.8	15.9	15.7	15.5
Ohio .....	6.4	4.7	6.0	5.4	6.2

The Bureau has many other sources of referral including educational institutions, hospitals, welfare agencies, workmen's compensation, interested individuals, and artificial appliance companies. It is hoped that the following analysis will provide physicians some useful information concerning the problems

and statistics of vocational rehabilitation with which we are all faced.

## The Rehabilitation Problem in Ohio

The U. S. National Health Survey 1957-1959<sup>1</sup> of the non-institutionalized civilian population reports the average number of work days lost due to disability to be 69,741 days for persons over age 17 in the east north central states. It is also estimated that 9.8 per cent of the civilian population in our region of the country have some degree of chronic limitation of activity. The prevalence of selected chronic conditions per 1,000 population in our region has been reported by the survey to be: (1) Heart conditions, 28.2; (2) Diabetes, 8.7; (3) Arthritis and rheumatism, 63.6; (4) Asthma-hay fever, 48.6; (5) Visual impairment, 15.5; (6) Hearing impairment, 31.7; and (7) Paralysis of the major extremities, 5.3; for all ages. In addition, the area is reported to have an injury rate of 277.4 per 1,000 population. Even as approximations, these figures suggest a vast population of disabled persons, many of whom will not become known to the Ohio Bureau of Vocational Rehabilitation. One primary reason for this is a lack of awareness of the services available on the part of health agencies and institutions, physicians, and others who might refer cases. Copies of the bulletin, *Information for Referring Agencies and Physicians*,<sup>2</sup> are available on request.

## Trends in the State Program

In order to summarize the workings of the Ohio BVR, the characteristics of rehabilitants and the services available, a brief statistical resumé can be provided. Financially, the Ohio BVR more than pays its own way. For example during the fiscal year 1962-1963, the cost of this program to Ohio taxpayers from State revenue was approximately \$973,000. The direct savings in funds resulting from the rehabilitation of public assistance recipients and those receiving their support from public institutions such as the mentally ill and mentally retarded, amounted to about \$572,000, leaving \$401,000 of State expense in rehabilitating 2,547 persons. The annual earnings of these rehabilitants amounted to over seven million dollars, which would bring in

\*Dr. Coddington, Columbus, is Medical Administrative Consultant, Ohio State Board of Education, Bureau of Vocational Rehabilitation.

\*\*Dr. McDaniel, Columbus, is Supervisor of Research, Bureau of Vocational Rehabilitation.

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more than enough revenue to the State to defray the cost of restoring these individuals to economic, personal, and vocational independence. The distinct advantage of the vocational rehabilitation program to the residents of Ohio by having fewer persons absorbing revenue and larger numbers contributing to it is obvious from those figures.

In terms of the numbers of persons rehabilitated in recent years, figure 1 shows a progressive increase.<sup>3</sup> This is expected to level off in the next two years as a result of lack of resources for further expansion and development of the vocational rehabilitation program.\* Comparison of the rates in figure 1 with the estimate provided by the U. S. National Health survey suggests that the current rate of rehabilitation of disabled persons is far below the numbers who could benefit from these services.

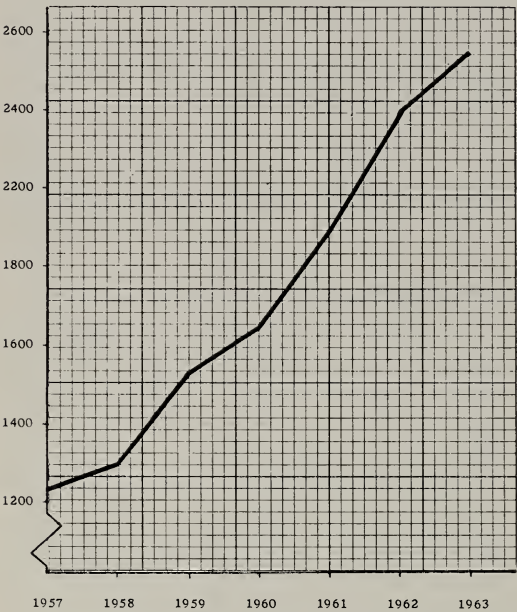


FIG. 1. Annual Numbers of Rehabilitants 1957 - 1963.

### Characteristics of Population Served

A more detailed analysis of the vocational rehabilitation program in Ohio is provided in Table 2 which elaborates upon the major disabilities of rehabilitated persons in 1962 and 1963 together with the disabilities of those rehabilitants referred specifically by Ohio physicians. In Table 2 it may be seen that the highest proportion of rehabilitated persons are those with orthopedic impairments, but that physician referred cases tend to fall disproportionately into this disability category. Among the types of disabilities regularly served by the rehabilitation program, physicians have apparently given least attention to referring cases of hearing loss, mental disturbances,

mental retardation, speech and visual impairments. On the other hand, cases of amputation or absence of limbs, orthopedic impairments, and cardiac diseases receive the greatest attention.

TABLE 2. Disabilities of All Rehabilitants and Those Referred by Physicians in 1962 and 1963

Disability Type	All Rehabilitants		Referred by Physicians	
	1962	1963	1962	1963
Amputation or Absence of Limbs	432	413	18	33
Orthopedic Impairment	736	743	60	65
Visual Impairment	125	143	5	7
Hearing Impairment	156	189	0	3
Speech Impairment	50	49	4	1
Mental Illness	280	303	9	11
Mental Retardation	122	179	3	3
Cardiac Diseases	120	131	15	18
Epilepsy	92	115	4	4
Tuberculosis, pulmonary	97	86	4	2
*Other Disabilities	181	196	6	12
Totals	2391	2547	128	159

\*Includes arthritis, diabetes, hernia, migraine and other conditions not elsewhere classified.

For the State program in general the percentages of most disability groups have remained relatively constant in recent years, the greatest change being a reduction in the percentage of cases with pulmonary tuberculosis and an increase in the percentage of the mentally ill and mentally retarded, which also reflects national trends. Some of the personal characteristics of persons rehabilitated are that they are annually about 75 per cent men and 25 per cent women and, in recent years, that the age distributions have averaged close to 70 per cent below the age of 35 with slightly more than 5 per cent over the age of 55 years.

### Services Provided the Disabled

The Ohio Bureau of Vocational Rehabilitation purchases or otherwise provides all services necessary to prepare or restore disabled individuals to suitable employment. How these services distributed themselves according to the number of clients receiving the services for a five-year period is shown in Table 3. Relatively large numbers of clients have had vocational training courses purchased for them to enable them to support themselves and their families in remunerative employment. However, a number of other required services are purchased which are also shown in Table 3.

Table 4 shows the various types of vocational training provided to persons of all disability categories distributed according to age. Among the most frequent types of vocational training which were provided rehabilitants in 1962 and 1963 were professional degree courses leading to college graduation, business college courses, vocational school, and on-the-job training by business and industrial establishments. By far, the most frequent age group for whom college training has been provided

\*The agency now has a professional field staff of 84 including field medical consultants located in 15 major Ohio cities.



has been those under age 20. Few disabled persons above age 45 have selected a college degree as part of their rehabilitation planning. It can be readily seen that disabled individuals above age 35 tend to select the short term business, vocational, and

ferent from the general population. Table 6 indicates the occupational levels in which rehabilitants have been distributed over the last five years. These distributions do not vary a great deal from year to year and it can be seen that the greatest numbers of dis-

TABLE 3. Case Services Purchased 1959 - 1963

Services Purchased	NUMBER OF CASES				
	1959	1960	1961	1962	1963
Diagnostic Examinations	2348	3837	4681	5119	4128
Surgery and Treatment	43	78	124	257	232
Prosthetic Appliances	286	349	420	518	420
Hospital and Convalescent Care	29	55	84	148	124
Training and Materials	1215	1570	1943	2525	2428
Maintenance and Transportation	517	695	853	1028	809
Tools, Equipment, and Licenses	87	80	104	136	107
Other Services	1	2	3	13	24
*By Rehabilitation or Adjustment Centers					1422
Total	4526	6666	8212	9744	9694

\*Category not used prior to 1963.

TABLE 4. Types of Vocational Training Provided Rehabilitants in 1962 and 1963, by Age

Type of Training	AGE GROUPS IN YEARS					Totals
	Under 20	20-34	35-44	45-54	55-64	
Professional Degrees	213	78	10	2	1	304
College below B.A. Level	15	17	3	0	0	35
Junior College	18	9	4	4	0	35
Business College	174	191	72	29	3	469
Specialized School	31	57	16	6	0	110
Vocational School	220	307	113	33	1	674
Correspondence Course	14	41	19	16	1	91
Rehabilitation Centers	36	37	12	13	1	99
Sheltered Workshops	32	64	18	22	3	139
On-Job Training	56	72	37	14	5	184
Tutor	3	4	3	1	0	11
Other Vocational	3	8	1	3	0	15
Totals	815	885	308	143	15	2166

on-the-job training courses as a means of vocational rehabilitation.

Personal adjustment training is frequently a requirement in rehabilitation, and Table 5 indicates the types of training employed and the frequencies of cases needing these services. Training in the use and care of a prosthesis is the most prevalent form

abled persons rehabilitated are employed in clerical, service, skilled, and semi-skilled occupations.

### Summary

In summary a very general statistical review of the activities and services of the Ohio Bureau of Vocational Rehabilitation has been presented, particular attention having been devoted to the types of disabling conditions with which the Bureau regularly deals, and the characteristics of cases referred by physicians. It should be noted that the percentage of rehabilitants referred by physicians in Ohio is considerably below average for all such State programs in the nation and that physician referrals tend to fall disproportionately into specific disability classifications. The conclusion has been reached that physicians might assume a more active role in insuring that vocational rehabilitation services reach those for whom they are intended, which includes patients having all types of mental and physical disabling conditions in all areas of the State of Ohio.

Since the specific individuals who receive vocational rehabilitation services depend heavily upon the activities of sources of referrals, it is hoped that providing some additional information to physicians will extend services to individuals who might other-

TABLE 5. Types of Personal Adjustment Training Provided Rehabilitants

Type of Training	1962		1963	
	No.	%	No.	%
Use of Prosthesis	72	39.8	99	39.8
Speech Correction	25	13.8	31	12.4
Lipreading	6	3.3	10	4.0
Self Care	3	1.7	5	2.0
Work Adjustment	65	35.9	89	35.8
Other	10	5.5	15	6.0
Totals	181	100%	249	100%

of personal adjustment training. Work adjustment or work conditioning training is also a common need, especially for many severely disabled, formerly institutionalized, or clients lacking experience in competitive employment.

Disabled persons are capable of functioning, vocationally speaking, in a range of occupations no dif-

TABLE 6. Major Occupational Groupings of Rehabilitants

Occupational Group	1959		1960		1961		1962		1963	
	No.	%	No.	%	No.	%	No.	%	No.	%
Professional .....	....	....	84	5.2	98	5.2	116	4.9	131	5.2
Semiprofessional and Managerial .....	*139	9.2	90	5.5	96	5.1	103	4.3	126	4.9
Clerical and Sales .....	365	24.2	364	22.4	434	23.1	468	19.6	499	19.6
Service Jobs .....	211	14.0	254	15.6	280	14.9	373	15.6	426	16.7
Agricultural and Allied .....	63	4.2	43	2.6	63	3.4	72	3.0	99	3.9
Skilled Jobs .....	259	17.2	235	14.5	279	14.9	376	15.7	408	16.0
Semiskilled Jobs .....	220	14.5	216	13.3	213	11.4	311	13.0	296	11.6
Unskilled Jobs .....	87	5.8	128	7.9	125	6.7	144	6.0	150	5.9
Sheltered Workshops (Severely disabled) .....	46	3.1	95	5.9	145	7.7	200	8.4	227	8.9
Homemakers .....	118	7.8	115	7.1	142	7.6	228	9.5	185	7.3
Total .....	1508	100%	1624	100%	1875	100%	2391	100%	254~	100%

\*Includes all professional, semiprofessional and managerial.

wise be delayed for some time until a health or welfare agency or institution calls attention to them as persons in need of vocational rehabilitation.

For numerous reasons, the delay between the onset of disability and initiation of a program of vocational rehabilitation has been found in the experience of the Bureau to be an important factor determining success. One essential goal, then, is not only to increase the range of referrals made by sources such as physicians, but also to encourage earlier referral.

To this end, any interested professionals desiring additional data or information are invited by the authors to make inquiries at any time.

### References

1. Health Statistics from the U.S. National Health Survey: *Selected Health Characteristics by Area: Geographic Division and Large Metropolitan Areas*. July 1957 - June 1959. Series C, No. 6, March, 1961.
2. Ohio Bureau of Vocational Rehabilitation, *Information for Referring Agencies and Physicians*. Revised March, 1964.
3. Ohio Bureau of Vocational Rehabilitation, *Forty-second Annual Report, Fiscal Year 1963*, December, 1963.

GENETICS can make some practical contributions to the medicine and surgery of to-day. There is the facilitating of early diagnosis when prompt treatment is important. A note of caution is struck, however, about the danger of overvaluing the family history in common diseases. There is the growing range of drug sensitivities having a genetic basis. Chromosome abnormalities are assuming a growing importance in a variety of intersex states and in a number of congenital defects, including Down's syndrome. The avoidance of genetic disease by making carriers aware of the danger of marrying each other has already made considerable progress in some parts of the world where some abnormal genes are frequent. There may ultimately be applications to genes which are rarer. The genetic effects of ionizing radiation, the management of hemolytic disease of the newborn, the whole business of blood transfusion, and medico-legal applications provide other examples. There can be little doubt, however, that the most important single application is the provision of genetic advice for those who need it. Useful advice can in fact be given in the great majority of instances.—J. A. Fraser Roberts, M. D., London, England: *British Medical Journal*, 2:1217-1221, November 14, 1964.

THE ART OF MEDICINE.—It might be a good plan if, in requesting laboratory or other special studies, we would make two separate lists under the following headings: *A*. Tests clearly indicated. *B*. Studies done to satisfy our personal curiosity. If the latter, the omission of which involves little or no calculated risk, were omitted, think of the reduced demand on our laboratories, the brakes on unnecessary studies and the more careful clinical considerations that would ensue. These considerations all have a bearing on the art of medicine. The tendency to put laboratory data first and clinical criteria second is the reverse of what it should be.—Garfield G. Duncan, M. D., Philadelphia, *Military Medicine*, 126:355-358, (May) 1961.



*Announcing*

# The Official Program

*for the*

1965 ANNUAL MEETING

Ohio State Medical Association

COLUMBUS

MAY 9-14



On the following pages are details of Ohio's Number One Post-graduate Program for Physicians. On the next page are highlights of the meeting. The succeeding pages contain the day-by-day schedule of events. Consult these daily schedules for time and place of event; then, for details as to subjects, speakers, etc., turn to the chronological program beginning on page 253.

## Highlights . . .

**Time and Place:** Sessions of the House of Delegates: Sunday, May 9, and Tuesday, May 11, beginning with a dinner at 6:00 p. m. on both days in the Columbus Plaza Hotel, 50 North Third Street in downtown Columbus. Reference Committees of the House will meet on Monday, May 10, and, if necessary, on Tuesday, May 11. Exhibits open at noon on Tuesday, May 11, in the Veterans Memorial Building, and the first Scientific Session opens at 2:00 p. m. Tuesday, also in the Veterans Memorial Building. (Ohio State Surgical Association program on Monday afternoon in the Columbus Plaza Hotel.)

**Registration:** Headquarters for Registration, the West Entrance Lobby, Ground Floor of the Veterans Memorial Building, 300 West Broad Street, Columbus, opening on Tuesday, May 11, at noon. Registration will be open on Wednesday and Thursday from 9:00 a. m. to 5:30 p. m. and on Friday from 9:00 a. m. to 2:00 p. m. Special provisions will be made to register persons attending sessions of the House of Delegates and its Reference Committee meetings.

Those eligible to register are members of the Ohio State Medical Association (who should present 1965 Membership Cards at time of registration); physicians from other states who are members of their respective state medical associations; residents, interns and medical students; nurses, health workers and others who are presented as guests at Registration Headquarters by members. Letters of introduction on members' stationery also will be honored at Registration Headquarters. The Woman's Auxiliary will provide registration at the Christopher Inn for its members and others who are eligible to attend Auxiliary sessions.

**Scientific Program:** Sessions begin on Tuesday, May 11, at 2:00 p. m. in the Veterans Memorial Building, and continue through Friday afternoon. At least one specialty group will hold a meeting on Saturday.

**Scientific and Technical Exhibits:** Exhibit Hall on the ground floor of the Veterans Memorial Building, open from noon to 5:00 p. m. on Tuesday; from 9:00 a. m. to 5:00 p. m. on Wednesday and Thursday, and from 9:00 a. m. to 2:00 p. m. on Friday. Ample recesses have been scheduled in the program to allow frequent visits to the exhibits.

**President's Reception:** This principal social event of the Annual Meeting is scheduled on Wednesday evening, beginning at 6:00 o'clock in the Columbus Plaza Hotel. There will be no dinner; merely an informal gathering with refreshments. Dress is optional for members and their guests. Dancing with music by Chuck Selby and his orchestra.

**The Woman's Auxiliary:** The Woman's Auxiliary to the Association will meet the same week as the OSMA meeting; headquarters, the Christopher Inn. All ladies eligible for membership in the Auxiliary are invited to attend sessions and special events. The Auxiliary is providing registration facilities at the Christopher Inn.

**Specialty Societies:** A number of Specialty Societies are cooperating with the Association in various phases of the program, and several are holding meetings or special events during the week. Consult the program for details.

**Emergency Telephone Service:** The Academy of Medicine of Columbus and Franklin County will maintain an information booth near the West Entrance Lobby on the ground floor of the Veterans Memorial Building, open while events are scheduled in the building. Names of physicians called are placed on a bulletin board. The special telephone at the booth will be announced later.



# SCHEDULE OF EVENTS

**SUNDAY, MAY 9**

**COLUMBUS PLAZA HOTEL  
GAY AND THIRD STREETS  
COLUMBUS**

(Time Shown — Eastern Standard Time)

TIME	EVENT	PLACE
12:00 Noon to 5:00 P. M.	<b>OHIO ACADEMY OF MEDICAL HISTORY</b> (Luncheon, business meeting and afternoon program.)	Columbus Plaza Hotel Taft Room and Auditorium Third Floor
6:00 P. M.	<b>HOUSE OF DELEGATES COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, AND OSMA COUNCIL, TO BE FOLLOWED BY BUSINESS SESSION</b> (See Tuesday schedule for second session of House of Delegates.)	Columbus Plaza Hotel Saturn Room Second Floor

# SCHEDULE OF EVENTS

**MONDAY, MAY 10**

**COLUMBUS PLAZA HOTEL  
COLUMBUS**

(Time Shown — Eastern Standard Time)

TIME	EVENT	PLACE
9:00 A. M.	<b>MEETINGS OF HOUSE OF DELEGATES REFERENCE COMMITTEES</b> Resolutions Committee No. 1 Resolutions Committee No. 2 Resolutions Committee No. 3 Committee on President's Address Committee on Nominations (See Tuesday schedule for second session of House of Delegates.)	Columbus Plaza Hotel Auditorium, Third Floor China and Malay Rooms Second Floor North and Baltic Rooms Second Floor Taft Room, Third Floor Garfield and Hayes Rooms Third Floor
2:00 P. M.	<b>OHIO STATE SURGICAL ASSOCIATION</b> (Scientific Program and Business Meeting)	Columbus Plaza Hotel Venus and Mars Rooms Second Floor
6:30 P. M.	<b>OHIO STATE SURGICAL ASSOCIATION</b> (Cocktails and Banquet)	Columbus Plaza Hotel Saturn Room, Second Floor

# SCHEDULE OF EVENTS

TUESDAY, MAY 11

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

TIME	EVENT	PLACE
9:00 A. M. to 12:00 Noon	<b>MEDICAL MOTION PICTURES</b> "Highlights of the 1964 AMA Meeting" "The One Who Heals" "The Empty Chair" "Bilateral Scalene Lymph Node Excision, Bilateral Thoracic" "Emergency Resuscitation"	Columbus Plaza Hotel Venus Room Second Floor
9:00 A. M.	<b>MEETINGS OF HOUSE OF DELEGATES REFERENCE COMMITTEES ON RESOLUTIONS</b>  (These committees will meet if there is unfinished business from meetings on Monday.)	Columbus Plaza Hotel Auditorium, Third Floor Committee No. 1  China and Malay Rooms Second Floor Committee No. 2  North and Baltic Rooms Second Floor Committee No. 3
12:00 Noon	<b>REGISTRATION OPENS</b>	West Entrance Lobby, Exhibit Hall Ground Floor
12:00 Noon	<b>OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS</b>	Exhibit Hall Ground Floor
1:00 P. M.	<b>OHIO HEALTH COMMISSIONERS</b> (Meeting with Director of Health)	Rooms 206 - 207 Veterans Wing, Second Floor
2:00 P. M.	<b>OHIO HEALTH COMMISSIONERS INSTITUTE</b> "Current Concepts in Tuberculosis Control"	Rooms 206 - 207 Veterans Wing, Second Floor
2:00 P. M.	<b>GENERAL SESSION</b> (Program presented by the Ohio Committee on Trauma, American College of Surgeons.)	Assembly Hall Veterans Wing, First Floor
2:00 to 3:00 P. M.	"Treatment of Fractures of the Forearm and Wrist"	Assembly Hall Veterans Wing, First Floor
3:00 to 3:30 P. M.	<b>RECESS FOR TOUR OF EXHIBITS</b>	Exhibit Hall, Ground Floor

(Continued on Next Page)



# SCHEDULE OF EVENTS

**TUESDAY, MAY 11**

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

*(Tuesday's Schedule Continued)*

TIME	PLACE	EVENT
3:30 to 4:00 P. M.	"Fractures Involving the Hand — and Hand Injuries"	Assembly Hall Veterans Wing, First Floor
4:00 to 4:30 P. M.	"Prophylaxis Against Tetanus for the Wounded"	Assembly Hall Veterans Wing, First Floor
4:30 to 5:00 P. M.	"Newer Concepts in the Treatment of Fractures of the Spine"	Assembly Hall Veterans Wing, First Floor
5:30 P. M.	<b>OHIO COMMITTEE ON TRAUMA AMERICAN COLLEGE OF SURGEONS</b> (Reception)	Columbus Plaza Hotel Garfield-Hayes Rooms Third Floor
6:00 P. M.	<b>HOUSE OF DELEGATES COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, AND OSMA COUNCIL, FOLLOWED BY FINAL BUSINESS SESSION</b>	Columbus Plaza Hotel Saturn Room Second Floor
7:00 P. M.	<b>OHIO HEALTH COMMISSIONERS</b> (Banquet)	Pick-Fort Hayes Hotel 31 West Spring St.

# SCHEDULE OF EVENTS

WEDNESDAY, MAY 12

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

TIME	EVENT	PLACE
9:00 A. M.	REGISTRATION	West Entrance Lobby, Exhibit Hall Ground Floor
9:00 to 9:30 A. M.	TOUR OF EXHIBITS	Exhibit Hall, Ground Floor
9:30 A. M. to 12:00 Noon	OHIO HEALTH COMMISSIONERS INSTITUTE "Environmental Health"	Rooms 206 - 207 Veterans Wing, Second Floor
9:30 A. M.	GENERAL SESSION (Program presented by the Ohio Division, Inc., American Cancer Society)	Assembly Hall Veterans Wing, First Floor
9:30 A. M. to 9:45 A. M.	ADDRESSES OF WELCOME	Assembly Hall Veterans Wing, First Floor
9:45 to 10:05 A. M.	"Cancer of the Stomach and Distal Esophagus"	Assembly Hall Veterans Wing, First Floor
10:05 to 10:25 A. M.	"Cancer of the Urinary Bladder"	Assembly Hall Veterans Wing, First Floor
10:25 to 11:00 A. M.	RECESS FOR TOUR OF EXHIBITS	Exhibit Hall, Ground Floor
11:00 to 11:20 A. M.	"Leukemia"	Assembly Hall Veterans Wing, First Floor
11:20 to 11:40 A. M.	"Chemotherapy of Solid Tumors in Relation to the Head and Neck"	Assembly Hall Veterans Wing, First Floor
11:40 A. M. to 12:30 P. M.	Panel Discussion	Assembly Hall Veterans Wing, First Floor
1:30 to 3:10 P. M.	INTERNAL MEDICINE (Program by Section on Internal Medicine and Ohio Society of Internal Medicine)	Assembly Hall Veterans Wing, First Floor

(Continued on Next Page)



# SCHEDULE OF EVENTS

WEDNESDAY, MAY 12

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

(Wednesday's Schedule Continued)

TIME	EVENT	PLACE
1:30 to 3:00 P. M.	<b>PHYSICAL MEDICINE OCCUPATIONAL MEDICINE</b> (Program by Section on Physical Medicine and Ohio Society of Physical Medicine and Rehabilitation)	Veterans Wing Mezzanine (One flight up from Exhibit Hall)
2:00 to 5:00 P. M.	<b>OHIO HEALTH COMMISSIONERS INSTITUTE</b> "Maternal and Child Health"	Rooms 206 - 207 Veterans Wing, Second Floor
3:00 to 3:30 P. M.	<b>RECESS FOR TOUR OF EXHIBITS</b>	Exhibit Hall, Ground Floor
3:30 to 5:00 P. M.	<b>CONTINUATION OF SPECIALTY MEETINGS</b>	
6:00 to 8:00 P. M.	<b>THE PRESIDENT'S RECEPTION</b> Cocktails — Music — Dancing	Columbus Plaza Hotel Venus - Mars - Jupiter - Saturn Rooms Second Floor
6:30 P. M.	<b>OHIO SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION</b> (Social hour, dinner and guest speaker)	The Christopher Inn 300 East Broad St.
7:30 P. M.	<b>INTERNAL MEDICINE</b> (Reception and Dinner Sponsored by Section on Internal Medicine and Ohio Society of Internal Medicine)	Columbus Plaza Hotel North - Baltic - China - Malay Rooms Second Floor

# SCHEDULE OF EVENTS

THURSDAY, MAY 13

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

TIME	EVENT	PLACE
9:00 A. M.	<b>REGISTRATION</b>	West Entrance Lobby, Exhibit Hall Ground Floor
9:00 to 9:30 A. M.	<b>TOUR OF EXHIBITS</b>	Exhibit Hall, Ground Floor
9:30 A. M. to 12:00 Noon	<b>OHIO HEALTH COMMISSIONERS INSTITUTE</b> "Research Value of Public Health Records"	Rooms 206 - 207 Veterans Wing, Second Floor
9:00 A. M.	<b>GENERAL SESSION</b> (Program presented by the Ohio State Heart Association)	Assembly Hall Veterans Wing, First Floor
9:00 to 9:30 A. M.	"Management of Shock of Acute Myocardial Infarction"	Assembly Hall Veterans Wing, First Floor
9:30 to 10:00 A. M.	"Coronary Vasodilators"	Assembly Hall Veterans Wing, First Floor
10:00 to 10:30 A. M.	<b>RECESS FOR TOUR OF EXHIBITS</b>	Exhibit Hall, Ground Floor
10:30 to 11:30 A. M.	Rudolph Allen Gerlinger Memorial Lecture "Rationale and Proper Use of Digitalis"	Assembly Hall Veterans Wing, First Floor
11:30 A. M. to 12:30 P. M.	"Digitalis Toxicity"	Assembly Hall Veterans Wing, First Floor
12:00 Noon	<b>OHIO OPHTHALMOLOGICAL SOCIETY</b> (Luncheon)	Athletic Club of Columbus 136 East Broad St.
1:30 to 3:00 P. M.	<b>EAR, NOSE AND THROAT</b> (Program by the Section on Ear, Nose and Throat and the Ohio Ear, Nose and Throat Society)	Veterans Wing Mezzanine (One flight up from exhibit hall)
1:50 to 3:00 P. M.	<b>OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS SECTION ON RADIOLOGY</b>	South Terrace Ground Floor
2:00 to 3:00 P. M.	<b>ANESTHESIOLOGY GENERAL PRACTICE OF MEDICINE</b> (Program by Section on Anesthesiology and Section on General Practice of Medicine)	Assembly Hall Veterans Wing, First Floor

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# SCHEDULE OF EVENTS

THURSDAY, MAY 13

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

(Thursday's Schedule Continued)

TIME	EVENT	PLACE
2:00 to 3:00 P. M.	<b>OPHTHALMOLOGY</b> (Program by Section on Ophthalmology and Ohio Ophthalmological Society)	Room 102 Veterans Wing, First Floor
2:00 to 3:00 P. M.	<b>CONFERENCE ON LABORATORY MEDICINE</b> (Program by OSMA Committee on Laboratory Medicine and the Ohio Society of Pathologists)	Rooms 206 - 207 Veterans Wing, Second Floor
2:00 to 5:00 P. M.	<b>OHIO HEALTH COMMISSIONERS INSTITUTE</b> "Latency, Activation and Control of Infectious Diseases"	Main Stage (Enter through main auditorium)
3:00 to 3:30 P. M.	<b>RECESS FOR TOUR OF EXHIBITS</b>	
3:30 to 5:00 P. M.	<b>CONTINUATION OF SPECIALTY MEETINGS</b>	
6:00 P. M.	<b>OHIO EAR, NOSE AND THROAT SOCIETY</b> (Cocktails and Dinner)	Columbus Plaza Hotel Venus Room, Second Floor
6:00 P. M.	<b>OHIO PSYCHIATRIC ASSOCIATION AND CENTRAL OHIO NEUROPSYCHIATRIC SOCIETY</b> (Social hour and dinner)	Columbus Plaza Hotel Mars Room, Second Floor
8:00 P. M.	<b>OHIO EAR, NOSE AND THROAT SOCIETY</b> (Business meeting and Speaker on "Otology in Orbit")	Columbus Plaza Hotel Venus Room Second Floor
8:00 P. M.	<b>OHIO PSYCHIATRIC ASSOCIATION AND CENTRAL OHIO NEUROPSYCHIATRIC SOCIETY</b> Speaker on: "Depression and Normality: Psychosomatic Aspects"	Columbus Plaza Hotel Mars Room Second Floor

# SCHEDULE OF EVENTS

FRIDAY, MAY 14

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

TIME	EVENT	PLACE
9:00 A. M.	<b>REGISTRATION</b>	West Entrance Lobby, Exhibit Hall Ground Floor
9:00 to 9:30 A. M.	<b>TOUR OF EXHIBITS</b>	Exhibit Hall, Ground Floor
9:30 to 10:30 A. M.	<b>PSYCHIATRY AND NEUROLOGY</b> (Program by Section on Psychiatry and Neurology and Ohio Psychiatric Association)	Veterans Wing Mezzanine (One flight up from exhibit hall)
9:30 A. M.	<b>OSMA GENERAL SESSION</b> (Program by Faculty, Ohio State University College of Medicine)	Assembly Hall Veterans Wing, First Floor
9:30 to 10:30 A. M.	<b>OSMA GENERAL SESSION</b> What I Do About: The Child with a Head Injury The Patient with Hemiplegia The Patient with Hearing Problems The Patient with a Thyroid Nodule The Patient with Psoriasis The Smoking Problem	Assembly Hall Veterans Wing, First Floor
10:30 to 11:00 A. M.	<b>RECESS FOR TOUR OF EXHIBITS</b>	Exhibit Hall, Ground Floor
11:00 A. M. to 12:00 Noon	<b>OSMA GENERAL SESSION</b> What I Do About: The Obese Patient Pharyngitis in Children The Use of Corticosteroids in Ocular Disease Menstrual Problems Patients with Diarrhea The Meningitis Suspect	Assembly Hall Veterans Wing, First Floor
11:00 A. M. to 12:00 Noon	<b>PSYCHIATRY AND NEUROLOGY</b> (Continuation of scientific program)	Veterans Wing Mezzanine (One flight up from exhibit hall)

(Continued on Next Page)



# SCHEDULE OF EVENTS

FRIDAY, MAY 14

(All sessions on Eastern Standard Time at the Veterans Memorial Building,  
300 West Broad Street, unless otherwise indicated.)

(Friday's Schedule Continued)

TIME	EVENT	PLACE
12:00 Noon to 2:00 P. M.	<b>PSYCHIATRY AND NEUROLOGY</b> (Luncheon and Speaker on "Community Psychiatry — A New Profession, A Developing Sub-Specialty or Effective Clinical Psychiatry")	Columbus Plaza Hotel Venus Room Second Floor
2:00 to 3:00 P. M.	<b>NEUROLOGICAL SURGERY</b> (Program by Section on Neurological Surgery and Ohio Neurosurgical Society)	Lower Mezzanine Lounge (Use stairway from Assembly Hall Foyer)
2:00 to 3:30 P. M.	<b>OBSTETRICS AND GYNECOLOGY</b> (Program by Section on Obstetrics and Gynecology)	Room 102 Veterans Wing, First Floor
2:00 to 3:00 P. M.	<b>PATHOLOGY</b> (Program by Section on Pathology and Ohio Society of Pathologists)	Assembly Hall Veterans Wing, First Floor
2:00 to 3:20 P. M.	<b>PEDIATRICS</b> (Program by Section on Pediatrics and Ohio Chapter, American Academy of Pediatrics)	Room 205 Veterans Wing, Second Floor
2:00 to 3:00 P. M.	<b>PSYCHIATRY AND NEUROLOGY</b> (Continuation of scientific program)	Veterans Wing Mezzanine (One flight up from exhibit hall)
3:00 to 3:30 P. M.	<b>RECESS</b>	
3:30 to 5:00 P. M.	<b>CONTINUATION OF SPECIALTY MEETINGS</b>	
7:00 P. M.	<b>OHIO SOCIETY OF PATHOLOGISTS</b> (Dinner)	Jai Lai Restaurant 1421 Olentangy River Road

# DELEGATES AND ALTERNATES

Counties	Delegates	Alternates
<b>FIRST DISTRICT</b>		
ADAMS	Francis Stevens	Juan Young
BROWN	John A. Powell	Charles H. Maly
BUTLER	Paul N. Ivins	James L. Sawyer
	John H. Varney	John A. Stewart
CLERMONT	Carl A. Minning	Richard Kirby
CLINTON	Edmond K. Yantes	Richard R. Buchanan
HAMILTON	John J. Cranley	William C. Ahlering
	Joseph G. Crotty	Frederick Brockmeier
	Joseph E. Ghory	Taylor W. Barker
	Ralph S. Grace	Louis C. Buente
	Harry K. Hines	Robert W. Buckley
	Daniel V. Jones	Kenneth A. Frederick
	Carl W. Koehler	Bruce G. MacMillan
	Howard F. C. Pfister	H. Willis Ratledge
	Clyde S. Roof	Eli Rubenstein
	Harold S. Schiro	
	Garfield L. Suder	
	Albert D. Weyman	
	Robert M. Woolford	
HIGHLAND	J. Martin Byers	Clifford G. Foor
WARREN		

<b>SECOND DISTRICT</b>		
CHAMPAIGN	Isador Miller	Victor R. Frederick
CLARK	David D. Smith	Max H. Gerke
	Ernest H. Winterhoff	William B. Williamson
DARKE	Maurice M. Kane	V. Ray Boli
GREENE	Roger C. Henderson	Paul C. Vernier
MIAMI	Dale A. Hudson	J. L. Hammon
MONTGOMERY	Kenneth D. Arn	Daniel E. Brannen
	Robert A. Bruce	John R. Brown
	J. R. Strawsburg	Marion V. Lingle
	James G. Tye	John H. Muehlstein
	Sylvan L. Weinberg	William M. Porter
PREBLE	C. J. Brian	J. R. Williams
SHELBY	George J. Schroer	Thomas W. Hunter

<b>THIRD DISTRICT</b>		
ALLEN	Dwight L. Becker	David A. Barr
	Fred P. Berlin	Norman Browning, Jr.
AUGLAIZE	Elizabeth Y. Kuffner	Robert S. Oyer
CRAWFORD	Horace Newhard	D. D. Bibler
HANCOCK	Donald R. Brumley	Thomas W. Darnall
HARDIN	C. L. Johnson	W. F. Binkley
LOGAN	Ralph K. Updegraff	Charles A. Browning
MARION	Albert Morg	Paul E. Lyon
MERCER	George H. McIlroy	Donald R. Fox
SENECA	Walter A. Daniel	Emmet T. Sheeran
VAN WERT	Edward E. White	Edwin W. Burnes
WYANDOT	Donald P. Smith	Clarence B. Schoolfield

<b>FOURTH DISTRICT</b>		
DEFIANCE	Charles E. Jaekle	Francis M. Lenhart
FULTON	William J. Neal	Benjamin H. Reed, Jr.
HENRY	Edwin C. Wenzler	Thomas F. Moriarty
LUCAS	Edmond F. Glow	George Bates
	William G. Henry	James I. Collins
	Edward F. Ockuly	John B. Sawyer
	Frederick P. Osgood	Merl Smith
	Frank F. A. Rawling	Gordon M. Todd
	Max T. Schnitker	Randolph P. Whitehead
OTTAWA	V. William Wagner	Cyrus R. Wood
PAULDING	D. E. Farling	Roy R. Miller
PUTNAM	Milo B. Rice	James B. Overmier
SANDUSKY	Robert A. Borden	A. C. Rini
WILLIAMS	Robert W. Dilworth	Allen G. Jackson
WOOD	Paul F. Orr	Clarence B. Nyce

<b>FIFTH DISTRICT</b>		
ASHTABULA	Shepard A. Burroughs	James G. Macaulay
CUYAHOGA	James O. Barr	Joseph C. Avellone
	Joseph L. Bilton	Garry G. Bassett
	William F. Boukalik	C. A. Colombi
	John H. Budd	Russell B. Crawford
	E. Peter Coppedge, Jr.	Nicholas G. DePiero
	Eduard Eichner	Joseph K. Doran
	Eugene A. Ferreri	John J. Gaughan
	David Fishman	Robert A. Hahn
	William E. Forsythe	C. R. Jablonoski
	John J. Grady	Richard P. Levy
	Harry A. Haller	Frederick V. Light
	Fred R. Kelly	Thomas F. Meaney
	Vincent T. LaMaida	Hermann Menges, Jr.
	M. H. Lambright	J. Kenneth Potter
	L. Philip Longley	Russell P. Rizzo
	L. J. McCormack	Leo H. Simoson
	Paul A. Mielecarek	Emil A. Steiner
	George W. Petznick	Howard P. Taylor
	John H. Sanders	Allen E. Walker
	A. B. Schneider, Jr.	Leo Walzer
	Frederick T. Suppes	Robert F. Williams
	Elden C. Weckesser	Julius Wolkin
GEAUGA	Raymond I. Smith	Simon Onahanasian
LAKE	Alfred C. Mahan	J. W. Koelliker
	G. Robert Smith	

Counties	Delegates	Alternates
<b>SIXTH DISTRICT</b>		
COLUMBIANA	John A. Fraser	Paul Beaver
MAHONING	G. E. DeCicco	H. N. Bennett
	S. F. Gaylord	L. P. Caccamo
	J. V. Newsome	L. J. Gasser
	C. W. Stertzbach	C. E. Pichette
PORTAGE	Edward A. Webb	David S. Palmstrom
STARK	Aubrey R. Furnas, Jr.	A. S. Abbel
	Maurice F. Lieber	F. O. Goodnough
	G. D. Underwood	E. E. Grable
SUMMIT	W. A. White, Jr.	Millard C. Beyer
	William Dornier, Jr.	R. J. Burkhard
	T. W. Jackson	D. W. Mathias
	James W. Parks	F. F. Somma
	Leonard V. Phillips	R. E. Yeakley
	James G. Roberts	
TRUMBULL	F. J. Waickman	L. A. Loria
	Raymond Ralston	Steven A. Pollis
	Rex K. Whiteman	

<b>SEVENTH DISTRICT</b>		
BELMONT	Robert N. Lewis	James F. Sutherland
CARROLL	Samuel L. Weir	Thomas J. Atchison
COSHOCTON	Norman L. Wright	N. Harry Carpenter
HARRISON	Elias Freeman	Charles Evans
JEFFERSON	Carl F. Goll	H. W. Haverland
MONROE		
TUSCARAWAS	R. E. Rinderknecht	W. E. Hudson

<b>EIGHTH DISTRICT</b>		
ATHENS	Robert E. Main	D. R. Johnson
FAIRFIELD	J. L. Kraker	Chester P. Swett
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	William M. Wells	R. G. Manning
MORGAN	A. A. Coulson	Henry Bachman
MUSKINGUM	Joseph C. Greene	Carl E. Spragg
NOBLE	E. G. Ditch	F. M. Cox
PERRY	O. D. Ball	Sydney N. Lord
WASHINGTON		

<b>NINTH DISTRICT</b>		
GALLIA	Keith R. Brandeberry	L. W. Starr
HOCKING	J. S. Matthews	Carl J. Greever
JACKSON	C. C. Fitzpatrick	Thomas E. Miller
LAWRENCE	Harry Nenni	S. J. Blazewicz
MEigs	Roger P. Daniels	Maek E. Moore
PIKE	A. M. Shrader	Sol Asch
SCIOTO	William Singleton	
VINTON		

<b>TENTH DISTRICT</b>		
DELAWARE	A. R. Callander	D. K. Michel
FAYETTE	Robert A. Heiny	J. H. Persinger
FRANKLIN	Homer A. Anderson	James C. Good
	Joseph A. Bonta	Charles J. Hatfield
	Drew J. Arnold	Robert A. Heilman
	William E. Hunt	Thomas M. Hughes
	John R. Huston	George O. Kress
	Robert M. Inglis	Torrence A. Makley
	Charles W. Pavey	Alexander Pollack
	Allen D. Puppel	Samuel Saslaw
	Donald W. Traphagen	Mark L. Saylor
KNOX	James C. McLarnan	Henry T. Lapp
MADISON	Sol Maggied	John C. Starr
MORROW	Joseph P. Ingmire	Francis W. Kubbs
PICKAWAY	Jasper M. Hedges	E. L. Montgomery
ROSS	Robert E. Swank	Lewis W. Coppel
UNION	E. J. Marsh	Fred C. Callaway

<b>ELEVENTH DISTRICT</b>		
ASHLAND	Charles H. McMullen	M. D. Shilling
ERIE	Emil J. Meckstroth	R. H. Williamson
HOLMES	A. J. Earney	Owen F. Patterson
HURON	William R. Graham	John Rosso
LORAIN	Charles Butrey	R. A. DeMarco
	James T. Stephens	D. E. Harrison
MEDINA	Richard W. Avery	William G. Halley
RICHLAND	Carroll E. Damron	C. K. Kuehne
	Carl M. Quick	James O. Ludwig
WAYNE	A. B. Huff	R. E. Reiheld

<b>OFFICERS</b>		
Pres	Robert E. Tschantz	Treas. Philip B. Hardyman
Pres.-Elect	Henry A. Crawford	Past-Pres. Horatio T. Pease

COUNCILORS			
District		District	
First	Robert E. Howard	Seventh	Benj. C. Diefenbach
Second	Theodore L. Light	Eighth	Robert C. Beardsley
Third	Frederick T. Merchant	Ninth	George Newton Spears
Fourth	Robert N. Smith	Tenth	Richard L. Fulton
Fifth	P. John Robechek	Eleventh	Lawrence C. Meredith
Sixth	Edwin R. Westbrook		



## SUNDAY, MAY 9

12:00 Noon (E. S. T.)

### MEDICAL HISTORY

Taft Room and Auditorium, Third Floor  
Columbus Plaza Hotel

Annual Meeting of Ohio Academy of Medical History  
President: Alexander T. Bunts, M. D., Cleveland

### THE PARTICIPANTS

William Brueggemann, M. D., Cincinnati.  
John R. Cummings, M. D., Cincinnati.  
Ralph W. Dexter, Ph. D., Kent.  
Jayne Ellison, Columbus.  
Bruno Gebhard, M. D., Cleveland.  
Phillips F. Greene, M. D., New Richmond.  
N. Paul Hudson, M. D., Columbus.  
Kenneth I. E. Macleod, M. D., M. P. H., Cincinnati.  
Robert M. Stecher, M. D., Cleveland.  
Adolph E. Waller, Ph. D., Columbus.

12:00 Noon Luncheon — Taft Room, Columbus  
Plaza Hotel.

After-Luncheon Speaker: Dr. Gebhard.  
"The Doctor Travels with Karl Baedeker"

1:45 Business Meeting.

2:00 Some Notable Ohio Physicians Who Con-  
tributed to Natural History—Dr. Dexter.

Dr. Levi Rogers, State Senator—Dr. Greene.

Medical Journalism in Ohio—Mrs. Ellison.

Yellow Fever in Ohio — Dr. Hudson.

Contagious Diseases at City Hospital in  
Cleveland — Dr. Stecher.

Two Careers in the Life of Linnaeus — Dr.  
Waller.

The 18th and 19th Century Physicians of  
North America of Scottish Birth, Des-  
cent, or Education — A Small Piece of  
Chauvinism To Be Sure — Dr. Macleod.

Medical Fiction Library—Dr. Brueggemann.

What's in a Name? — Dr. Cummings.

5:00 Adjournment.

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### Extra Meeting Scheduled?

A number of small groups usually arrange a dinner, social event or program during the Annual Meeting. Some of these affairs appear in the program. Other organizations are invited to leave information at the Registration desk as to time, place, etc., so that data may be passed to members who inquire there.

## SUNDAY, MAY 9

6:00 P. M. (E. S. T.)

### HOUSE OF DELEGATES

### COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, AND OSMA COUNCIL, TO BE FOLLOWED BY BUSINESS SESSION

Saturn Room, Second Floor  
Columbus Plaza Hotel

Invocation.

Welcome by John R. Huston, M. D., Columbus,  
President of the Columbus Academy of Medicine.

Introduction of the President, Robert E. Tschantz,  
M. D., Canton.

Roll Call of Delegates.

Consideration of the Minutes of the last Annual  
Meeting (June 1964, issue of *The Journal*).

Introduction of honored guests.

Report by the President of the Woman's Auxiliary  
— Mrs. John Dickie, Toledo.

Appointment of Reference Committees by the Presi-  
dent:

Credentials.

President's Address.

Resolutions.

Tellers and Judges of Election.

Nomination and election of Committee on Nomi-  
nations: (Nominations from the floor. One rep-  
resentative (delegate) from each Councilor Dis-  
trict. The committee shall report to the Second  
Session, Tuesday, May 11, 6:00 P. M., its recom-  
mendations in the form of a ticket containing  
nominees for offices to be filled at this meeting  
as required under the Constitution and Bylaws.)

Introduction of Resolutions:

(Resolutions must be introduced at this session of  
the House of Delegates, referred to the Reference  
Committees on Resolutions, and reported back to  
the House of Delegates at the Tuesday evening  
session before any action can be taken. All resolu-  
tions must be typewritten and submitted in  
triplicate.)

Announcements of meeting places of Committee on  
Nominations and Reference Committees by chair-  
men of the committees.

Miscellaneous business.

Announcements of Annual Meeting events.

Recess.

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Planners of the program have gone to great lengths  
to bring to Ohio outstanding authorities as guest  
speakers at the Annual Meeting. Read the program  
carefully and note the topics these colleagues from  
other states are scheduled to present. Then make a  
date to hear these visitors from other areas.

## MONDAY, MAY 10

9:00 A. M. (E. S. T.)

### HOUSE OF DELEGATES REFERENCE COMMITTEES

Columbus Plaza Hotel

Resolutions Committee No. 1

Auditorium, Third Floor

Resolutions Committee No. 2

China and Malay Rooms, Second Floor

Resolutions Committee No. 3

North and Baltic Rooms, Second Floor

Committee on President's Address

Taft Room, Third Floor

Committee on Nominations

Garfield and Hayes Rooms, Third Floor

Meetings of House of Delegates Reference Committees. Any member of the Association is privileged to attend these meetings.

Many hours of effort have gone into building and arranging the Scientific and Educational Exhibits. Many of them are short courses in compact form, representing years of study or research. Make a point to visit these exhibits often and talk to the people who sponsor them.

## MONDAY, MAY 10

2:00 P. M. (E. S. T.)

### OHIO STATE SURGICAL ASSOCIATION

Venus and Mars Rooms, Second Floor

Columbus Plaza Hotel

2:00 Past-Presidents' Round Table.

An open discussion of topics of current interest to the medical profession. Off-the-record remarks by past-presidents of the Association in answer to all questions raised from the floor. Round-table style. For members only. Closed to the press.

4:00 Annual business meeting.

Installation of Robert C. Smith, M. D., Circleville, President-Elect, by Frank L. Shively, Jr., M. D., Dayton, President.

6:30 P. M.

Saturn Room

Columbus Plaza Hotel

Cocktail hour.

7:30 P. M.

Banquet.

Ohio surgeons who have donated their services to Project Hope to be honored. Principal speaker — William B. Walsh, M. D., Washington, D. C., Director of the People-to-People Health Foundation.

## Deadline for Submission of Resolutions to Columbus Office of the Association Is March 10

**D**ELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1965 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal*, must be introduced at the first session of the House of Delegates, Sunday evening, May 9, at the Columbus Plaza Hotel.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must have been filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 10. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.



## **TUESDAY, MAY 11**

9:00 A. M. (E. S. T.)

### **MEDICAL MOTION PICTURES**

Venus Room, Second Floor  
Columbus Plaza Hotel

Presiding: Isador Miller, M. D., Urbana, Member of the Committee on Scientific Work.

9:00 **Highlights of the 1964 AMA Meeting**  
Medifilm No. 6. 32 minutes.

**The One Who Heals**  
Religion and Medicine. 27 minutes.

10:00 **The Empty Chair**  
G. Douglas Talbott, M. D., Dayton. 28 minutes.

11:00 **Bilateral Scalene Lymph Node Excision, Bilateral Thoracic Duct Cannulation**  
William H. Falor, M. D., Akron. 20 minutes.

**Emergency Resuscitation**  
Stewart Hardy Films, Ltd.

## **TUESDAY, MAY 11**

9:00 A. M. (E. S. T.)

Columbus Plaza Hotel

Resolutions Committee No. 1  
Auditorium, Third Floor

Resolutions Committee No. 2  
China and Malay Rooms, Second Floor

Resolutions Committee No. 3  
North and Baltic Rooms, Second Floor

The House of Delegates Reference Committees on Resolutions will meet if there is unfinished business from meetings on Monday. Any member of the Association is privileged to attend these meetings.

## **TUESDAY, MAY 11**

12:00 Noon (E. S. T.)

### **REGISTRATION OPENS**

West Entrance Lobby, Exhibit Hall, Ground Floor  
Veterans Memorial Building  
12:00 Noon (E. S. T.)

### **OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS**

Exhibit Hall, Ground Floor  
Veterans Memorial Building

## **TUESDAY, MAY 11**

1:00 P. M. (E. S. T.)

### **OHIO HEALTH COMMISSIONERS**

Rooms 206 - 207, Veterans Wing, Second Floor  
Veterans Memorial Building

1:00 Meeting with Ohio Director of Health.

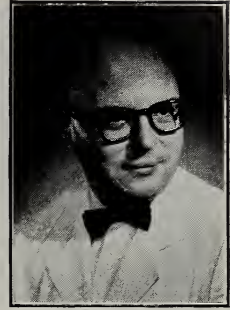
2:00 **Current Concepts in Tuberculosis Control**  
— Walter L. Evans, M. D., Chief, Division of Tuberculosis, Ohio Department of Health.

7:00 Banquet, Pick-Fort Hayes Hotel.

## **Guest Participants**



Robert E. Carroll, M. D.  
New York City



L. F. Peltier, M. D., Ph. D.  
Kansas City, Kan.

## **TUESDAY, MAY 11**

2:00 P. M. (E. S. T.)

### **GENERAL SESSION**

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building

Program sponsored by the Ohio Committee on Trauma,  
American College of Surgeons.

### **THE PARTICIPANTS**

Robert E. Carroll, M. D., New York, N. Y., Associate Clinical Professor of Orthopaedic Surgery, Columbia University College of Physicians and Surgeons; Chief, Hand Service, New York Orthopaedic Hospital.

Wesley L. Furste, M. D., Columbus, Member, Subcommittee on Prophylaxis Against Tetanus of the National Committee on Trauma, American College of Surgeons.

Leonard F. Peltier, M. D., Ph. D., Kansas City, Kan., Professor of Surgery and Head of Section of Orthopaedic Surgery, University of Kansas School of Medicine.

Joseph M. Strong, M. D., Elyria, Chairman, Orthopaedic Service, Elyria Memorial Hospital.

Presiding: Thomas W. Morgan, M. D., Gallipolis, Chairman, Ohio Committee on Trauma, American College of Surgeons.

2:00 **Treatment of Fractures of the Forearm and Wrist** — Dr. Strong.

3:00 Recess for Tour of Exhibits.

3:30 **Fractures Involving the Hand— and Hand Injuries** — Dr. Carroll.

4:00 **Prophylaxis Against Tetanus for the Wounded** — Dr. Furste.

4:30 **Newer Concepts in the Treatment of Fractures of the Spine** — Dr. Peltier.

5:00 Adjournment.

5:30 P. M.

Columbus Plaza Hotel  
Garfield-Hayes Rooms

Reception, Ohio Committee on Trauma,  
American College of Surgeons

## TUESDAY, MAY 11

6:00 P. M. (E. S. T.)

### HOUSE OF DELEGATES

#### COMPLIMENTARY DINNER FOR DELEGATES, ALTERNATES, AND OSMA COUNCIL, FOLLOWED BY FINAL BUSINESS SESSION

Saturn Room, Second Floor  
Columbus Plaza Hotel

Roll Call of Delegates.

Introduction of honored guests.

Consideration of unfinished business.

Reports of Reference Committees:

President's Address.

Resolutions.

Election of President-Elect. Nominations from the floor.

Report of Committee on Nominations.

(a) Nominations for The Council.

(Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in odd-numbered years.) To be elected:

**Second District** — (Incumbent, Theodore L. Light, M. D., Dayton.)

**Fourth District** — (Incumbent, Robert N. Smith, M. D., Toledo.)

**Sixth District** — (Incumbent, Edwin R. Westbrook, M. D., Warren.)

**Eighth District** — (Incumbent, Robert C. Beardsley, M. D., Zanesville.)

**Tenth District** — (Incumbent, Richard L. Fulton, M. D., Columbus.)

(b) Election of Delegates and Alternates to the American Medical Association — five Delegates and five Alternates to be elected, each for a two-year term starting January 1, 1966, in compliance with the Constitution and Bylaws of the American Medical Association.

The following incumbent Delegates and Alternates will serve for the remainder of 1965 and they may be considered by the nominating committee for reelection for two-year terms starting January 1, 1966:

Edwin H. Artman, M. D., Chillicothe  
(Delegate)

Phillip B. Hardymon, M. D., Columbus  
(Alternate)

(Continued in Next Column)

### Resolutions for Annual Meeting To Be Published in April

Resolutions to be presented before the House of Delegates at the OSMA 1965 Annual Meeting, and forwarded to the OSMA office before the deadline, March 10, will be published in the April issue of *The Journal*, and copies forwarded to members of the House.

Only a duly authorized member of the House of Delegates may present resolutions. Resolutions must be introduced in triplicate. This must be done at the first session of the House of Delegates on Sunday, May 9, even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

A resolution not filed with the Executive Secretary 60 days before the meeting may be presented only if the deadline requirement is waived by a vote of at least two-thirds of the House of Delegates present at the first session.

John H. Budd, M. D., Cleveland  
(Delegate)

P. John Robeck, M. D., Cleveland  
(Alternate)

Richard L. Meiling, M. D., Columbus  
(Delegate)

Robert E. Tschantz, M. D., Canton  
(Alternate)

Paul F. Orr, M. D., Perrysburg  
(Delegate)

Frederick P. Osgood, M. D., Toledo  
(Alternate)

Charles A. Sebastian, M. D., Cincinnati  
(Delegate)

J. Robert Hudson, M. D., Cincinnati  
(Alternate)

Installation of officers for 1965-1966.

Submission of committee appointments by the new President for confirmation by the House of Delegates.

Unfinished or new business.

Adjournment.



## WEDNESDAY, MAY 12

9:00 A. M. (E. S. T.)

### REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor  
Veterans Memorial Building  
9:00 to 9:30 A. M.

### TOUR OF EXHIBITS

## WEDNESDAY, MAY 12

9:30 A. M. (E. S. T.)

### OHIO HEALTH COMMISSIONERS INSTITUTE

Rooms 206 - 207  
Veterans Wing, Second Floor  
Veterans Memorial Building

Environmental Health — George H. Eagle, Chief,  
Bureau of Environmental Health, Ohio Department of Health.

12:00 Noon

Lunch.

(See Next Column for the afternoon program.)

## WEDNESDAY, MAY 12

9:30 A. M. (E. S. T.)

### GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building  
Eighth Annual Cancer Conference presented by the  
American Cancer Society, Ohio Division, Inc.

### THE PARTICIPANTS

Daniel Bergsagel, M. D., Toronto, Canada, Chief of  
Medicine, Ontario Cancer Institute.

Charles A. Doan, M. D., Columbus, Dean Emeritus,  
Ohio State University College of Medicine.

Harry Grabstald, M. D., New York, N. Y., Associate  
Attending Surgeon, Urologic Service, Memorial  
Sloan-Kettering Cancer Center.

Richard H. Jesse, M. D., Houston, Texas, Associate  
Surgeon, Head and Neck Service, M. D. Anderson  
Hospital and Tumor Institute, University of  
Texas Medical Center.

Gordon P. McNeer, M. D., New York, N. Y., At-  
tending Surgeon and Chief of Gastric and Mixed  
Tumor Service, Memorial Sloan-Kettering Cancer  
Center.

Spencer Northup, M. D., Toledo, President, Ameri-  
can Cancer Society, Ohio Division, Inc.

Wilford D. Nusbaum, M. D., Lancaster, Chairman,  
Eighth Annual Cancer Conference.

Robert E. Tschantz, M. D., Canton, President, Ohio  
State Medical Association.

Presiding: Dr. Nusbaum.

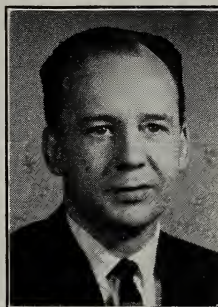
9:30 Welcome — Drs. Northup and Tschantz.

9:45 Cancer of the Stomach and Distal Esoph-  
agus — Dr. McNeer.

10:05 Cancer of the Urinary Bladder — Dr.  
Grabstald.

(Continued in Next Column)

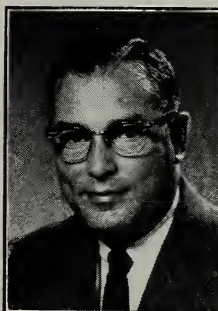
## Guest Participants



Daniel Bergsagel, M. D.  
Toronto, Canada



Harry Grabstald, M. D.  
New York City



Richard H. Jesse, M. D.  
Houston, Texas



Gordon P. McNeer, M. D.  
New York City

- 10:25 Recess for Tour of Exhibits.  
(Suggest the American Cancer Society exhibit  
on "Pitfalls in Cancer Management" be  
viewed.)
- 11:00 Leukemia — Dr. Bergsagel.
- 11:20 Chemotherapy of Solid Tumors in Relation  
to the Head and Neck — Dr. Jesse.
- 11:40 Panel Discussion.  
Moderator — Dr. Doan.  
Members of Panel: Drs. Bergsagel, Grab-  
stald, Jesse and McNeer.
- 12:30 Adjournment.  
(Acceptable for Category II Credit by the  
American Academy of General Practice.)

## WEDNESDAY, MAY 12

2:00 P. M. (E. S. T.)

### OHIO HEALTH COMMISSIONERS INSTITUTE

Rooms 206 - 207  
Veterans Wing, Second Floor  
Veterans Memorial Building

Maternal and Child Health — Effie O. Ellis, M. D.,  
Chief, Division of Maternal and Child Health,  
Ohio Department of Health.

**WEDNESDAY, MAY 12**

2:00 P. M. (E. S. T.)

**INTERNAL MEDICINE**

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building

Program sponsored by the Section on Internal Medicine  
and the Ohio Society of Internal Medicine.

**All Physicians Urged to Attend  
This Program**

Since this program has been assigned the time usually devoted to a general session, family physicians and those practicing in other specialties are cordially invited, and strongly urged to attend.—Maurice A. Schnitker, M. D., Chairman, Committee on Scientific Work.

**THE PARTICIPANTS**

Edward Buonocore, M. D., Cleveland, Department of Radiology, Cleveland Clinic.

Joseph M. Foley, M. D., Cleveland, Professor, Department of Neuropsychiatry, University Hospitals, Cleveland.

Grant W. D. Gwinup, M. D., Columbus, Assistant Professor, Department of Medicine, Ohio State University College of Medicine.

Henry D. McIntosh, M. D., Durham, North Carolina, Professor, Department of Medicine and Director of Cardiovascular Laboratory, Duke University School of Medicine, Durham, N. C.

1:30 Opening remarks — Robert Schoene, M. D., Chairman, Section on Internal Medicine.

Greetings — A. Carlton Ernstene, M. D., Cleveland, President, American College of Physicians; and Richard W. Vilter, M. D., Cincinnati, Ohio Governor, American College of Physicians.

1:45 What's New on Obesity? — Dr. Gwinup.

2:05 Lymphangiography — Dr. Buonocore.

2:30 The Remedial Causes of Dementing Diseases — Dr. Foley.

3:10 Recess for Tour of Exhibits.

3:40 Business Meeting and Election of Officers, OSMA Section on Internal Medicine.

3:50 Cardioversion — Dr. McIntosh.

5:00 Business Meeting, Ohio Society of Internal Medicine.

5:10 Adjournment.

The foregoing program was arranged under the direction of the following: Robert H. Schoene, M. D., Columbus, Chairman, and William F. Bradley, M. D., Columbus, secretary.

*(Continued in Next Column)*

**Guest Participants**



Donald L. Rose, M. D.  
Kansas City, Kan.



Henry D. McIntosh, M. D.  
Durham, N. C.

tary, Section on Internal Medicine; John J. Grady, M. D., Cleveland, President, and Sanford F. Gaylord, M. D., Youngstown, Secretary-Treasurer, Ohio Society of Internal Medicine; and James V. Warren, M. D., Columbus, Professor and Chairman, Department of Medicine; and Sidney W. Nelson, M. D., Columbus, Professor and Chairman, Department of Radiology, Ohio State University College of Medicine.

7:30 P. M.

(Following OSMA President's Reception)

North - Baltic - China - Malay Rooms

Second Floor

Columbus Plaza Hotel

Reception and Dinner, Ohio Society of Internal  
Medicine and OSMA Section on Internal  
Medicine.

The Technical Exhibits are as varied as the medical supply field is broad. Watch for those "Recesses" in the program and make a point to visit the exhibits often.



**WEDNESDAY, MAY 12**

2:00 P. M. (E. S. T.)

**PHYSICAL MEDICINE AND REHABILITATION  
OCCUPATIONAL MEDICINE**

Veterans Wing Mezzanine  
(One flight up from Exhibit Hall)  
Veterans Memorial Building

Program sponsored by the Section on Physical Medicine and Rehabilitation and the Ohio Society of Physical Medicine and Rehabilitation

**THE PARTICIPANTS**

Ben L. Boynton, M. D., Akron, Medical Director, Rehabilitation Center of Summit County, Inc.

Harriet E. Gillette, M. D., Cleveland, Staff Member, Department of Physical Medicine and Rehabilitation, Cleveland Clinic.

Ernest W. Johnson, M. D., Columbus, Professor and Chairman, Department of Physical Medicine, Ohio State University College of Medicine.

Karl J. Olsen, M. D., Cleveland, Department of Physical Medicine, Cleveland Clinic.

Donald L. Rose, M. D., Kansas City, Kan., Professor, Department of Physical Medicine, University of Kansas School of Medicine.

Marvin H. Spiegel, M. D., Columbus, Department of Physical Medicine, Ohio State University.

Presiding: Dr. Olsen.

**Management of the Painful Shoulder**

- 1:30 Etiology — Dr. Rose.  
2:45 Examination of the Neck and Upper Extremity — Dr. Johnson.  
3:00 Recess for Tour of Exhibits.  
3:30 Methods of Treatment — Drs. Olsen and Spiegel.  
4:15 Panel Discussion.  
Moderator: Dr. Olsen.  
Trigger Points and Injections — Dr. Boynton.  
Shoulder-Hand Syndrome — Dr. Rose.  
Cervical Traction — Dr. Spiegel.  
Immobilization — Dr. Gillette.  
5:00 Election of Officers for 1966, Section on Physical Medicine and Rehabilitation.  
Election of Officers for 1966, Section on Occupational Medicine, Room 205, Veterans Wing, Second Floor.

The foregoing program was arranged under the direction of the following: John D. Guyton, M. D., Worthington, Chairman, and Karl J. Olsen, M. D., Cleveland, Secretary, Section on Physical Medicine and Rehabilitation; Richard D. Burk, M. D., Columbus, President, Ben L. Boynton, M. D., Akron, Secretary, Ohio Society of Physical Medicine and Rehabilitation.

6:30 P. M.

The Christopher Inn  
300 East Broad St.

Social hour and dinner meeting of the Ohio Society of Physical Medicine and Rehabilitation, "Who Is a Physiatrist?" — Donald L. Rose, M. D., Kansas City, Kansas.

**Announcing**

**The President's Reception**

6:00 to 8:00 p. m.

**Wednesday, May 12, 1965**

**Venus-Mars-Jupiter-Saturn Rooms,  
Second Floor  
Columbus Plaza Hotel**



Social highlight of the 1965 Annual Meeting.

A congenial get-together where members, their ladies and guests may gather for refreshments, dancing and the atmosphere of a social period.

**NO SPEECHES — NO FORMAL PROGRAM  
DRESS: OPTIONAL**



Hors D'Oeuvres

will be served by the Association

Cash Bar Will Be Open



Following adjournment of the reception at 8:00 o'clock, members and guests will have ample time to dine at the place of their choosing.



Dancing to the accompaniment  
of

**CHUCK SELBY AND HIS ORCHESTRA**

## THURSDAY, MAY 13

9:00 A.M. (E. S. T.)

### REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor  
Veterans Memorial Building

9:00 to 9:30 A.M.

### TOUR OF EXHIBITS

## THURSDAY, MAY 13

9:00 A.M. (E. S. T.)

### GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building

Program presented by the Ohio State Heart Association

### THE PARTICIPANTS

Phillip Horowitz, M.D., Toledo, Associate Staff,  
Toledo Hospital.

George Morrice, Jr., M.D., Columbus, Chairman of  
Program Committee.

George G. Rowe, M.D., Madison, Wis., Professor  
of Medicine, Cardiovascular Section, University of  
Wisconsin Medical School.

Joseph M. Ryan, M.D., Columbus, Professor, De-  
partment of Medicine and Chief of Heart Station,  
Ohio State University College of Medicine.

Paul N. Yu, M.D., Rochester, N. Y., Professor, De-  
partment of Medicine and Head, Cardiopulmonary  
Unit, School of Medicine and Dentistry, Univer-  
sity of Rochester.

Presiding: Dr. Morrice.

Drug Therapy of Cardiac Disease

Moderator: Dr. Morrice.

9:00 Management of Shock of Acute Myocar-  
dial Infarction — Dr. Horowitz.

9:30 Coronary Vasodilators — Dr. Rowe.

10:00 Recess for Tour of Exhibits.

10:30 Rationale and Proper Use of Digitalis —  
Dr. Yu.

(Rudolph Allen Gerlinger Memorial Lec-  
ture of the Northwestern Ohio Heart  
Association.)

(Introduction of speaker by J. Lester Ko-  
backer, M.D., Toledo, Past - President,  
Northwestern Ohio Heart Association.)

11:30 Digitalis Toxicity — Dr. Ryan.

Questions from the audience will be accepted after  
each presentation, time permitting.

## THURSDAY, MAY 13

10:00 A.M. (E. S. T.)

### OHIO OPHTHALMOLOGICAL SOCIETY

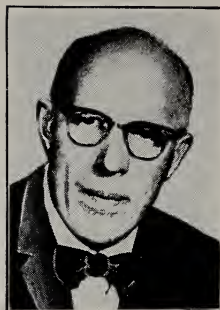
Athletic Club of Columbus  
136 East Broad St.

Business meeting.

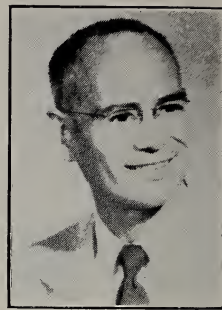
12:00 Noon (E. S. T.)

Luncheon.

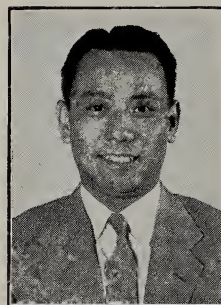
## Guest Participants



René Jules Dubos, Ph. D.  
New York City



George G. Rowe, M. D.  
Madison, Wis.



Paul N. Yu, M. D.  
Rochester, N. Y.

## THURSDAY, MAY 13

9:30 A.M. (E. S. T.)

### OHIO HEALTH COMMISSIONERS INSTITUTE

Rooms 206 - 207

Veterans Wing, Second Floor  
Veterans Memorial Building

9:30 Research Value of Public Health Records  
— William H. Veigel, Chief, Division of  
Vital Statistics, Ohio Department of  
Health.

12:00 Noon. Lunch.

## THURSDAY, MAY 13

2:00 P.M. (E. S. T.)

### OHIO HEALTH COMMISSIONERS INSTITUTE

Main Stage

(Enter through main auditorium)

Latency, Activation and Control of Infec-  
tious Diseases—René Jules Dubos, Ph. D.,  
New York City.

5:00 Adjournment.



## THURSDAY, MAY 13

1:30 P. M. (E. S. T.)

### EAR, NOSE AND THROAT

Veterans Wing Mezzanine  
(One flight up from exhibit hall)

Program sponsored by the Section on Ear, Nose and Throat and the Ohio Ear, Nose and Throat Society.

#### THE PARTICIPANTS

Robert E. Boswell, M. D., Dayton, Department of Otolaryngology, Good Samaritan Hospital.

Raymond L. Hilsinger, M. D., Cincinnati, Assistant Professor, Department of Otolaryngology, University of Cincinnati College of Medicine.

Howard P. House, M. D., Los Angeles, Calif., Clinical Professor of Otolaryngology, University of Southern California School of Medicine; Director, Los Angeles Foundation of Otolaryngology.

Gerson Lowenthal, M. D., Cincinnati, Associate Clinical Professor, Department of Otolaryngology, University of Cincinnati College of Medicine.

Fred R. Tingwald, M. D., Cleveland, Member of Otolaryngology Staff, Cleveland Clinic.

1:30 **Current Concepts of Tonsil and Adenoid Surgery** — Dr. Tingwald.

1:50 Open Discussion.

2:00 **Clinical Facets of Inner Ear Problems** — Dr. House.

2:40 Open Discussion.

3:00 Recess for Tour of Exhibits.

3:30 **Parotid Problems** — Dr. Boswell.

3:50 Discussion opened by Dr. Lowenthal.

4:00 **Headaches Secondary to Nasal Abnormalities** — Dr. Hilsinger.

4:20 Open Discussion.

4:30 Election of Officers for 1966.

The foregoing program was arranged under the direction of the following: Charles E. Kinney, M. D., Cleveland, Chairman of the Section on Ear, Nose and Throat and President of the Ohio Society of Ear, Nose and Throat; William J. Krech, M. D., Columbus, Secretary, Section on Ear, Nose and Throat and Secretary-Treasurer of the Ohio Society of Ear, Nose and Throat.

6:00 P. M.

### Ohio Ear, Nose and Throat Society

Venus Room, Second Floor  
Columbus Plaza Hotel

Cocktails and dinner for members and wives (informal).

8:00 P. M.

Business Meeting.

8:15 P. M.

"Otolaryngology in Orbit" — Howard P. House, M. D., Los Angeles.

## Guest Participants



Howard P. House, M. D.  
Los Angeles, Calif.



Averill Liebow, M. D.  
New Haven, Conn.

## THURSDAY, MAY 13

1:50 P. M. (E. S. T.)

### OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

#### SECTION ON RADIOLOGY

South Terrace, Ground Floor  
Veterans Memorial Building

Program sponsored by the Ohio Chapter of the American College of Chest Physicians and the Section on Radiology.

1:50 Business meeting, Section on Radiology.

2:00 P. M.

#### A Panorama of Chest Disease

Clinical — Radiological — Pathological

A panel of experts will discuss a number of interesting cases of chest disease from the aspect of these three disciplines. The discussions will be illustrated with projected slides.

#### Pathology

Averill Liebow, M. D., New Haven, Conn., Professor of Pathology, Yale University College of Medicine.

#### Radiology

Benjamin Felson, M. D., Cincinnati, Professor of Radiology, University of Cincinnati College of Medicine.

#### Clinical-Physiological

Joseph Tomashefski, M. D., Columbus, Director of Research, Ohio State Tuberculosis Hospital.

(If you are a clinician come and try your ability against Dr. Tomashefski. If you are a radiologist put your interpretation against that of Dr. Felson. If you are a pathologist come and see if you agree with Dr. Liebow. This is a tough trio — but not that tough!)

3:00 to 3:30 P. M. Recess for Tour of Exhibits.

4:45 Business meeting, American College of Chest Physicians.

The foregoing program was arranged under the direction of the following: R. L. Witt, M. D., Cincinnati, President; Neil C. Andrews, M. D., Columbus, Secretary - Treasurer, Ohio Chapter, American College of Chest Physicians; Jerome F. Wiot, M. D., Cincinnati, Chairman, and John F. Dorst, M. D., Cincinnati, Secretary, Section on Radiology.

## THURSDAY, MAY 13

2:00 P. M. (E. S. T.)

### OPHTHALMOLOGY

Room 102  
Veterans Wing, First Floor  
Veterans Memorial Building

Program sponsored by the Section on Ophthalmology and the Ohio Ophthalmological Society

### THE PARTICIPANTS

James M. Andrew, M. D., Columbus, Associate Professor of Ophthalmology, Ohio State University College of Medicine.

James E. Bennett, M. D., Cleveland, Senior Clinical Instructor of Ophthalmology, Western Reserve University School of Medicine.

Richard H. Keates, M. D., Columbus, Assistant Professor of Ophthalmology, Ohio State University College of Medicine.

William H. Spencer, M. D., San Francisco, Calif., Assistant Clinical Professor of Ophthalmology, University of California School of Medicine.

2:00 **Interesting Causes of Unilateral Exophthalmos in Children** — Dr. Spencer.

2:45 **Management of Congenital Nystagmus** — Dr. Bennett.

3:00 **The Removal of Recurrent Orbital Hemangioma** — Dr. Andrew.

3:15 **Election of Officers for 1966.**

3:30 **Recess for Tour of Exhibits.**

4:00 **The Use of Scleral Lenses in Chronic Corneal Disease** — Dr. Keates.

4:30 **Adjournment.**

The foregoing program was arranged under the direction of the following: Robert A. Bruce, M. D., Dayton, Chairman, James M. Andrew, M. D., Columbus, Secretary, Section on Ophthalmology; W. H. Evans, M. D., Youngstown, President, Robert H. Magnuson, M. D., Columbus, Secretary-Treasurer, Ohio Ophthalmological Society.

### Ohio Ophthalmological Society

Business meeting: Thursday, May 13, 10 A. M. to 12:00 Noon, Athletic Club of Columbus, 136 East Broad Street.

Luncheon: Thursday, May 13, 12:00 Noon, Athletic Club.

## Guest Participants



Jay Jacoby, M. D.  
Milwaukee, Wis.



William H. Spencer, M. D.  
San Francisco, Calif.

## THURSDAY, MAY 13

2:00 P. M. (E. S. T.)

### CONFERENCE ON LABORATORY MEDICINE

Main Stage  
(Enter through main auditorium)  
Veterans Memorial Building

Program sponsored by the Committee on Laboratory Medicine of the Ohio State Medical Association and the Ohio Society of Pathologists.

### THE PARTICIPANTS

Effie O. Ellis, M. D., Columbus, Chief, Child Hygiene Division, Ohio Department of Health.

M. Neil Macintyre, Ph. D., Cleveland, Associate Professor, Department of Anatomy, Western Reserve University School of Medicine.

Juan F. Sotos, M. D., Columbus, Program Director, Children's Study Center, Children's Hospital.

Ralph L. Zucker, M. D., Toledo, Medical Director, Lucas County Diagnostic and Evaluation Clinic for Retarded Children.

Presiding: Horace B. Davidson, M. D., Columbus, Chairman, Committee on Laboratory Medicine, Ohio State Medical Association.

### Retarded Child: Genetic and Metabolic Approaches to Diagnosis

2:00 **Statement of Problem** — Dr. Zucker.

2:30 **Programs and Facilities in Ohio** — Dr. Ellis.

3:00 **Recess for Tour of Exhibits.**

3:30 **Metabolic Aspects** — Dr. Sotos.

4:15 **Chromosome Studies** — Dr. Macintyre.

5:00 **Adjournment.**

The foregoing program was arranged under the direction of the following members of the Committee on Laboratory Medicine of the Ohio State Medical Association: Horace B. Davidson, M. D., Columbus, Chairman; William H. Benham, M. D., Toledo; John B. Hazard, M. D., Cleveland; Melvin Oosting, M. D., Dayton; Arthur E. Rappoport, M. D., Youngstown; William B. Smith, M. D., Zanesville; Phillip B. Wasserman, M. D., Cincinnati; and the following officers of the Ohio Society of Pathologists: Robert G. Thomas, M. D., Elyria, President; L. J. McCormack, M. D., Cleveland, Secretary; and Colin R. Macpherson, M. D., Columbus, Program Chairman.



## THURSDAY, MAY 13

2:00 P. M. (E. S. T.)

### ANESTHESIOLOGY GENERAL PRACTICE OF MEDICINE

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building

Program sponsored by the Sections on Anesthesiology and  
General Practice of Medicine.

#### THE PARTICIPANTS

J. C. Appleton, M. D., Anesthesiologist, Associate  
Attending Staffs, Miami Valley Hospital, and Good  
Samaritan Hospital.

N. G. DePiero, M. D., Cleveland, Director of Anes-  
thesiology, Marymount Hospital.

J. P. Garvin, Columbus, Director of Anesthesiology,  
Columbus Children's Hospital.

William E. Hamelberg, M. D., Columbus, Director  
of Anesthesiology, Ohio State University Hospital.

Jay Jacoby, M. D., Milwaukee, Wis., Professor of  
Anesthesiology, Marquette University School of  
Medicine.

Thomas E. Rardin, M. D., Columbus, Assistant Pro-  
fessor, Department of Preventive Medicine, Ohio  
State University College of Medicine.

Louise O. Warner, M. D., Ashville, Anesthesiologist,  
Columbus Children's Hospital.

C. E. Wasmuth, M. D., Cleveland, Department of  
Anesthesiology, Cleveland Clinic.

C. M. Welch, M. D., Columbus, Assistant Professor  
of Anesthesiology, University Hospital.

Presiding: Lester E. Imboden, M. D., Columbus,  
Chairman, Section on Anesthesiology.

2:00 Medicolegal Problems — Dr. Wasmuth.

2:30 Expanding Role of Anesthesiology — Dr.  
Jacoby.

3:00 Recess for Tour of Exhibits.

3:30 Management of the Airway — Dr. DePiero.

3:50 Operating Room Deaths and Resuscitation  
— A Current Look — Dr. Garvin.

4:10 The Referring Doctor — Dr. Warner.

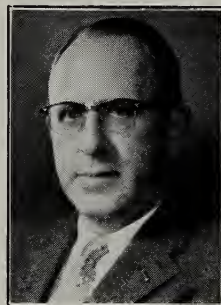
4:30 Pain Management (Panel Discussion)  
Moderator: Dr. Hamelberg.

Members of Panel: Drs. Jacoby, Welch,  
Rardin, and Appleton.

5:00 Election of Officers for 1966.

The foregoing program was arranged under the direction  
of the following: Lester E. Imboden, M. D., Columbus,  
Chairman, Nicholas G. DePiero, M. D., Cleveland, Secre-  
tary, Section on Anesthesiology; M. M. Groban, M. D.,  
Dayton, Chairman, Thomas M. Hughes, M. D., Columbus,  
Secretary, Section on General Practice of Medicine.

## Guest Participant



Roy R. Grinker, Sr., M. D.  
Chicago, Ill.

## THURSDAY, MAY 13

6:00 P. M. (E. S. T.)

### OHIO PSYCHIATRIC ASSOCIATION AND CENTRAL OHIO NEUROPSYCHIATRIC SOCIETY

Mars Room, Second Floor  
Columbus Plaza Hotel

Social hour and dinner.

Members of the Ohio Psychiatric Association will  
be guests of the Central Ohio Neuropsychiatric So-  
ciety at the social hour.

8:00 P. M.

Depression and Normality; Psychosomatic Aspects  
— Roy R. Grinker, Sr., M. D., Chicago, Director,  
Institute for Psychosomatic and Psychiatric Re-  
search and Training, Michael Reese Hospital Medi-  
cal Center.

### Jefferson Medical Alumni Reunion Scheduled May 13

A get-together is planned for the alumni of Jef-  
ferson Medical College, their wives and guests who  
attend the 1965 Annual Meeting, scheduled this  
year at the University Club of Columbus, 40 South  
Third Street, Thursday, May 13.

Activities will begin with a "fellowship hour"  
at 6 p. m., followed by dinner at 7:30, and "Brief  
Speeches about JEFF" at 8:30 p. m. Alumni are  
urged to attend any portion of the program that  
adapts to their schedule. However, those who plan  
to attend the dinner are requested to secure reserva-  
tions in advance if possible through: Dr. Anthony  
Ruppersberg, 336 East State Street, Columbus 15.  
Tickets may be purchased at the door on May 13.

## FRIDAY, MAY 14

9:30 A. M. (E. S. T.)

### REGISTRATION

West Entrance Lobby, Exhibit Hall, Ground Floor  
Veterans Memorial Building

9:00 A. M. (E. S. T.)

### TOUR OF EXHIBITS

## FRIDAY, MAY 14

9:00 A. M. (E. S. T.)

### PSYCHIATRY AND NEUROLOGY

Veterans Wing Mezzanine  
(One flight up from exhibit hall)  
Veterans Memorial Building

Program sponsored by the Section on Psychiatry and  
Neurology and the Ohio Psychiatric Association

### THE PARTICIPANTS

Tibor Agoston, M. D., Columbus, Director of Psychotherapy, Columbus State Hospital.

Theodor Bonstedt, M. D., Cincinnati, Instructor, Department of Psychiatry, University of Cincinnati College of Medicine.

Robert S. Daniels, M. D., Chicago, Ill., Associate Professor and Acting Chairman, Department of Psychiatry, University of Chicago School of Medicine.

John Donnelly, M. D., Hartford, Conn., Medical Director, Institute of Living.

Harold Hiatt, M. D., Cincinnati, Associate Clinical Professor, Department of Psychiatry, University of Cincinnati College of Medicine.

James R. Hodge, M. D., Akron, Chief, Psychiatry Section, Akron City Hospital.

Irving M. Rosen, M. D., Director of Community Services, Cleveland State Hospital.

Walter W. Winslow, M. D., Cincinnati, Instructor, Departments of Psychiatry and Preventive Medicine, and Industrial Health, University of Cincinnati College of Medicine.

Presiding: Dr. Hodge.

9:30 Psychotherapy in a Public Psychiatric Clinic  
— An Attempt at Adjustment — Dr.  
Bonstedt.

Discussant: Dr. Winslow.

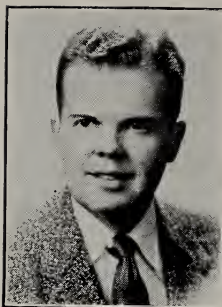
10:00 Psychotherapeutic Interpretations — Dr.  
Agoston.

Discussant: Dr. Hiatt.

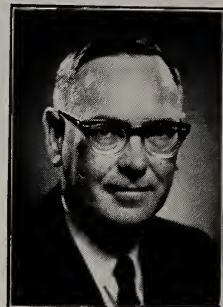
10:30 Recess for Tour of Exhibits.

*(Continued in Next Column)*

## Guest Participants



Robert S. Daniels, M. D.  
Chicago, Ill.



John Donnelly, M. D.  
Hartford, Conn.

11:00 Treatment of Character Disorders — Dr.  
Donnelly.

Discussant: Dr. Rosen.

11:50 Board Chartered Bus to Columbus Plaza Hotel.

12:00 Noon

Venus Room, Second Floor  
Columbus Plaza Hotel

Luncheon.

Community Psychiatry — A New Profession, A Developing Sub-Specialty or Effective Clinical Psychiatry — Dr. Daniels.

1:45 Board Chartered Bus to Veterans Memorial Building.

The foregoing program was arranged under the direction of the following: Irwin N. Perr, M. D., Cleveland, Victor M. Victoroff, M. D., Cleveland, Chairman and Secretary, respectively, of the Section on Psychiatry and Neurology and the Ohio Psychiatric Association; and Milton Kramer, M. D., Cincinnati, Program Chairman.

(See page 267 for the afternoon program of the Section on Psychiatry and Neurology and the Ohio Psychiatric Association.)



## FRIDAY, MAY 14

9:30 A. M. (E. S. T.)

### GENERAL SESSION

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building

### THE PARTICIPANTS

Program presented by the Faculty, Ohio State  
University College of Medicine.

Floyd M. Beman, M. D., Associate Professor, Department of Medicine.

Robert H. Browning, M. D., Professor, Department of Medicine.

William E. Copeland, M. D., Associate Professor, Department of Obstetrics and Gynecology.

Henry G. Cramblett, M. D., Professor, Department of Pediatrics.

George J. Hamwi, M. D., Professor, Department of Medicine.

William H. Havener, M. D., Professor, Department of Ophthalmology.

Eldred B. Heisel, M. D., Professor, Department of Medicine.

Ernest W. Johnson, M. D., Professor, Department of Physical Medicine.

Michael M. Paparella, M. D., Assistant Professor, Department of Otolaryngology.

Samuel Saslaw, M. D., Ph. D., Professor, Department of Medicine.

Martin P. Sayers, M. D., Associate Professor, Department of Neurosurgery.

Ralph G. Wieland, M. D., Assistant Professor, Department of Medicine.

Presiding: Maurice A. Schnitker, M. D., Toledo, Chairman, Committee on Scientific Work.

Moderator: Dr. Saslaw.

(10-minute presentations)

#### 9:30 What I Do About:

The Child with a Head Injury — Dr. Sayers.

The Patient with Hemiplegia — Dr. Johnson.

The Patient with Hearing Problems — Dr. Paparella.

The Patient with a Thyroid Nodule — Dr. Wieland.

The Patient with Psoriasis — Dr. Heisel.

The Smoking Problem — Dr. Browning.

#### 10:30 Recess for Tour of Exhibits.

(10-minute presentations)

#### 11:00 What I Do About:

The Obese Patient — Dr. Hamwi.

Pharyngitis in Children — Dr. Cramblett.

The Use of Corticosteroids in Ocular Disease — Dr. Havener.

Menstrual Problems — Dr. Copeland.

Patients with Diarrhea — Dr. Beman.

The Meningitis Suspect — Dr. Saslaw.

#### 12:00 Adjournment.

## FRIDAY, MAY 14

2:00 P. M. (E. S. T.)

### NEUROLOGICAL SURGERY

Lower Mezzanine Lounge  
(Use stairway from Assembly Hall Foyer)  
Veterans Memorial Building

Program sponsored by the Section on Neurological Surgery  
and the Ohio Neurosurgical Society.

### THE PARTICIPANTS

R. L. McLaurin, M. D., Cincinnati, Associate Professor and Director, Division of Neurosurgery, University of Cincinnati College of Medicine.

D. Bruce Sodee, M. D., Cleveland, Director, Department of Nuclear Medicine, Doctors Hospital.

Bruce F. Sorensen, M. D., Cleveland, Cleveland Clinic.

Thomas M. Tank, M. D., Cleveland, Cleveland Clinic.

Laurence M. Weinberger, Akron, Senior Attending Neurosurgeon, Akron General, Akron City, St. Thomas, and Akron Children's Hospitals.

Presiding: Dr. Turner.

2:00 Present Concepts of Brain Scanning with Radioactive Isotopes — Dr. Sodee.

3:00 Recess for Tour of Exhibits.

3:30 Calcified Subdural Hematomas in Childhood — Dr. McLaurin.

3:40 Spasmodic Torticollis — Review of 71 Surgically Treated Cases — Dr. Sorensen.

3:50 Experiences with Thermal Lobotomy for Intractable Pain — Dr. Weinberger.

4:00 Postoperative Aseptic Meningitis — Incidence, Pathogenesis and Prevention — Dr. Tank.

4:10 Discussion Period.

4:30 Election of Officers for 1966.

5:00 Adjournment.

The foregoing program was arranged under the direction of the following: Oscar A. Turner, M. D., Youngstown, and George H. Hoke, M. D., Lorain, Chairman and Secretary, respectively, Section on Neurological Surgery and the Ohio Neurosurgical Society.

**FRIDAY, MAY 14**

2:00 P. M. (E. S. T.)

**OBSTETRICS AND GYNECOLOGY**

Room 102

Veterans Wing, First Floor

Veterans Memorial Building

**THE PARTICIPANTS**

Jacoba C. deNeef, M. D., Ph. D., Columbus, Assistant Professor, Department of Obstetrics and Gynecology, Ohio State University College of Medicine.

Charles H. Hendricks, M. D., Cleveland, Professor, Department of Obstetrics and Gynecology, Western Reserve University School of Medicine.

Edward J. Quilligan, M. D., Cleveland, Chairman and Director, Department of Obstetrics and Gynecology, Cleveland Metropolitan General Hospital and Professor, Department of Obstetrics and Gynecology, Western Reserve University School of Medicine.

John C. Ullery, M. D., Columbus, Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine.

Nichols Vorys, M. D., Columbus, Assistant Professor, Department of Obstetrics and Gynecology, Ohio State University College of Medicine.

2:00 Ovarian Enlargement --- Dr. Ullery.

2:30 Induction of Labor --- Dr. Hendricks.

3:00 Fetal Distress --- Dr. Quilligan.

3:30 Recess for Tour of Exhibits.

4:00 The Treatment of Dysfunctional Uterine Bleeding --- Dr. Vorys.

4:30 The Value of Clinical Vaginal Endocrine Cytology --- Dr. deNeef.

5:00 Election of Officers for 1966.

5:10 Adjournment.

The foregoing program was arranged under the direction of the following: John G. Boutselis, M. D., Columbus, Chairman; Lester A. Ballard, Jr., M. D., Cincinnati, Secretary, Section on Obstetrics and Gynecology.

**Guest Participants**



Robert J. Lukes, M. D.  
Los Angeles, Calif.



Thomas K. Oliver, Jr. M. D.  
Seattle, Wash.

**FRIDAY, MAY 14**

2:00 P. M. (E. S. T.)

**PATHOLOGY**

Assembly Hall, Veterans Wing, First Floor  
Veterans Memorial Building

Program sponsored by the Section on Pathology and the Ohio Society of Pathologists.

**THE PARTICIPANTS**

G. Adolph Ackerman, M. D., Ph. D., Columbus, Professor, Department of Anatomy, Ohio State University College of Medicine.

Robert J. Lukes, M. D., Los Angeles, Calif., Professor, Department of Pathology, University of Southern California School of Medicine.

Robert L. Wall, M. D., Columbus, Associate Professor, Department of Medicine, Ohio State University College of Medicine.

2:00 Embryological Origin and Development of Lymphocytes in Thymus and Bursa of Fabricius --- Dr. Ackerman.

2:15 Therapy in the Lymphomas --- Dr. Wall.

2:30 A New Approach to the Pathologic Evaluation of Hodgkin's Disease --- Dr. Lukes.

3:00 Recess for Tour of Exhibits.

3:30 Slide Seminar on Lymph Node Biopsy --- Dr. Lukes.

5:30 Business meetings of Section on Pathology and the Ohio Society of Pathologists.

6:30 Adjournment.

The foregoing program was arranged under the direction of the following: Robert G. Thomas, M. D., Elyria, and L. J. McCormack, M. D., Cleveland, Chairman and Secretary, respectively, Section on Pathology and the Ohio Society of Pathologists; C. R. Macpherson, M. D., Columbus. Program Chairman.

7:00 P. M.

Jai Lai Restaurant

1421 Olentangy River Road

Dinner.



## FRIDAY, MAY 14

2:00 P. M. (E. S. T.)

### PEDIATRICS

Room 205

Veterans Wing, Second Floor

Veterans Memorial Building

Program sponsored by the Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics.

### THE PARTICIPANTS

Henry Cramblett, M. D., Columbus, Professor, Department of Pediatrics, Ohio State University College of Medicine.

Bruce Graham, M. D., Columbus, Professor and Chairman, Department of Pediatrics, Ohio State University College of Medicine.

Alvin Mauer, M. D., Cincinnati, Assistant Professor, Department of Pediatrics, University of Cincinnati College of Medicine.

Thomas K. Oliver, Jr., M. D., Seattle, Wash., Associate Professor, Department of Pediatrics, University of Washington School of Medicine.

Eugene V. Perrin, M. D., Cincinnati, Assistant Professor, Departments of Pediatrics and Pathology, University of Cincinnati College of Medicine.

C. Merle Welch, M. D., Columbus, Assistant Professor, Department of Surgery, Ohio State University College of Medicine.

### Knotty Natal Problems

Moderator: Dr. Graham.

2:00 Introduction — Dr. Graham.

2:10 Respiratory Distress — Dr. Oliver.

2:30 Analgesic and Anesthetic Agents Effect on the Newly-born Infant — Dr. Welch.

2:50 Neonatal Infection — Choice of Antibiotics — Dr. Cramblett.

3:10 Questions and Answers.

3:20 Recess for Tour of Exhibits.

3:45 Placenta as Diagnostic Tool — Dr. Perrin.

4:05 Erythroblastosis 1965 — Dr. Mauer.

4:25 Indications for Exchange Transfusions in Hyperbilirubinemia — Dr. Oliver.

4:45 Questions and Answers.

The foregoing program was arranged under the direction of the following: James J. Englert, M. D., Cincinnati, Chairman, Chester T. Kasmersky, M. D., Columbus, Secretary, Section on Pediatrics; Thomas E. Shaffer, M. D., Columbus, President, and Lawrence C. Thompson, M. D., Mansfield, Secretary-Treasurer, Ohio Chapter, American Academy of Pediatrics.

6:30 P. M.

Venus Room, Second Floor

Columbus Plaza Hotel

Social hour and dinner, Central Ohio Pediatric Society, Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics. Tickets may be purchased at the registration desk, Veterans Memorial Building, or from members of the societies.

## FRIDAY, MAY 14

2:00 P. M. (E. S. T.)

### PSYCHIATRY AND NEUROLOGY

Veterans Wing Mezzanine

(One flight up from exhibit hall)

Veterans Memorial Building

Program sponsored by the Section on Psychiatry and Neurology and the Ohio Psychiatric Association.

### THE PARTICIPANTS

J. Patrick Duffy, M. D., Cleveland, Assistant Professor, Department of Psychiatry, Western Reserve University School of Medicine.

Adolf Haas, M. D., Columbus, Assistant Professor, Department of Psychiatry, Ohio State University College of Medicine.

George T. Harding, Sr., M. D., Worthington, Medical Director, Harding Hospital.

Dwight M. Palmer, M. D., Columbus, Professor of Medicine (Neurology), Psychiatry and Anatomy, Ohio State University College of Medicine.

Philip Piker, M. D., Cincinnati, Professor of Psychiatry, University of Cincinnati College of Medicine.

H. J. Wahler, Ph. D., Psychologist, Mental Hygiene Clinic, Ohio State University College of Medicine.

Guy H. Williams, Jr., M. D., Cleveland, Department of Neurology, Cleveland Clinic.

Presiding: Dr. Duffy.

2:00 The Pathology and Treatment of the Relationship in Marriage — Dr. Haas.

Discussant: Dr. Wahler.

2:30 Doctors' Wives as Psychiatric Patients — Dr. Harding.

Discussant: Dr. Piker.

3:00 Recess for Tour of Exhibits.

3:30 Clinic Observations of Seven Cases of Creutzfeldt-Jakob Disease—Dr. Williams.

Discussant: Dr. Palmer.

4:00 Election of Section Officers for 1966. Business meeting and installation of officers, Ohio Psychiatric Association.

The foregoing program was arranged under the direction of the following: Irwin N. Perr, M. D., Cleveland, Victor M. Victoroff, M. D., Cleveland, Chairman and Secretary, respectively, of the Section on Psychiatry and Neurology and the Ohio Psychiatric Association; and Milton Kramer, M. D., Cincinnati, Program Chairman.

(See page 264 for the morning program of the Section on Psychiatry and Neurology and the Ohio Psychiatric Association.)

# Ohio Health Commissioners Institute, Columbus

To be Held in Conjunction with the Ohio  
State Medical Association Annual Meeting

**MAY 11 - 14, 1965**

All Meetings in Rooms 206 - 207

Veterans Wing, Second Floor

Except

Thursday, May 13, 2:00 P. M., Main Stage

Enter through Main Auditorium

Veterans Memorial Building

## **TUESDAY, MAY, 11**

12:00 Noon OSMA Registration Opens.

12:00 - 1:00 P. M. Lunch.

1:00 - 2:00 P. M. Meeting of Health Commissioners with Ohio Director of Health.

2:00 - 5:00 P. M. "Current Concepts in Tuberculosis Control" — Walter L. Evans, M. D., Chief, Division of Tuberculosis, Ohio Department of Health.

7:00 P. M. Health Commissioners Banquet, Pick-Fort Hayes Hotel.

## **WEDNESDAY, MAY 12**

9:30 A. M. - 12:00 Noon "Environmental Health" — George H. Eagle, Chief, Bureau of Environmental Health, Ohio Department of Health.

12:00 - 2:00 P. M. Lunch.

2:00 - 5:00 P. M. "Maternal and Child Health" — Effie O. Ellis, M. D., Chief, Division of Maternal and Child Health, Ohio Department of Health.

6:00 - 8:00 P. M. OSMA President's Reception, Columbus Plaza Hotel.

## **THURSDAY, MAY 13**

9:30 A. M. - 12:00 Noon "Research Value of Public Health Records" — William H. Veigel, Chief, Division of Vital Statistics, Ohio Department of Health.

12:00 Noon - 2:00 P. M. Lunch.

2:00 - 5:00 P. M. "Latency, Activation and Control of Infectious Diseases" — René Jules Dubos, Ph. D., Rockefeller Institute, New York City.

## **FRIDAY, MAY 14**

9:30 A. M. - 12:00 Noon OSMA General Session. Ten-minute talks on What I Do About . . . Presented by the Faculty, Ohio State University College of Medicine.

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### **Mental Retardation Center in Cincinnati Studied**

The University of Cincinnati has been awarded a \$20,000 grant from the Joseph P. Kennedy, Jr. Foundation to be used as "seed" money to develop plans that may lead to a new \$2.5 million mental retardation center in the Cincinnati community.

Twelve universities "with great potential in this work" received Kennedy planning grants.

The center in Cincinnati would house a number of agencies and contain facilities to help parents seeking aid for their mentally retarded children. It would probably be built adjacent to Children's Hospital and its Research Foundation, fitting in with long range plans of that institution.

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### **Environmental Health**

The Second American Medical Association Congress on Environmental Health Problems will be held at the Drake Hotel in Chicago, April 26-27.

Among physicians on the program will be Dr. Robert A. Kehoe, director of the Kettering Laboratory of the University of Cincinnati, whose topic will be "Physical and Chemical Changes in the Ambient Environment."



# Separate Events of Special Groups During Annual Meeting Week

IN addition to features in the Annual Meeting program, co-sponsored in many instances, a number of specialty societies and other special groups are holding independent meetings, luncheons and dinners for their respective members during the week of the OSMA Annual Meeting. Readers should consult the program for parts these groups are playing in the scientific program.

Following is information on events of special interest announced to *The Journal* before this issue went to press.

## SUNDAY, MAY 9

**Ohio Academy of Medical History:** Columbus Plaza Hotel, 50 North Third Street, Taft Room, 12 Noon, luncheon. Following the luncheon, Dr. Bruno Gebhard, Cleveland, Director of the Cleveland Health Museum, will speak on "The Doctor Travels with Karl Baedeker."

**Ohio Society of Anesthesiologists:** Columbus Plaza Hotel, 50 North Third Street, Garfield-Hayes Rooms, Third Floor, 12 Noon to 3 P. M., luncheon and meeting of the Board of Directors.

## MONDAY, MAY 10

**Ohio State Surgical Association:** Columbus Plaza Hotel, Saturn Room, Second Floor, 6:30 P. M., cocktail hour; 7:30 P. M., banquet; speaker: William B. Walsh, M. D., Washington, D. C., Director of the People-to-People Health Foundation.

## TUESDAY, MAY 11

**Ohio Committee on Trauma, American College of Surgeons:** Columbus Plaza Hotel, 50 North Third Street, Garfield-Hayes Rooms, Third Floor, 5:30 P. M., reception.

**Ohio Health Commissioners:** Pick-Fort Hayes Hotel, 31 West Spring Street, 7 P. M., banquet.

## WEDNESDAY, MAY 12

**Ohio Society of Physical Medicine and Rehabilitation:** The Christopher Inn, 300 East Broad Street, 6:30 P. M., social hour and dinner. Following the dinner, Dr. Donald L. Rose, Kansas City, will speak on "Who Is a Physiatrist?"

**Ohio Society of Internal Medicine:** Columbus Plaza Hotel, 50 North Third Street, North-Baltic-

China-Malay Rooms, Second Floor, 7:30 P. M., reception and dinner.

## THURSDAY, MAY 13

**Ohio Ophthalmological Society:** Columbus Athletic Club, 136 East Broad Street, 10 A. M., business meeting; 12 Noon, luncheon.

**Ohio Ear, Nose and Throat Society:** Columbus Plaza Hotel, 50 North Third Street, Venus Room, Second Floor, 6 P. M., cocktails and dinner; 8 P. M., business meeting; 8:15 P. M., Dr. Howard P. House, Los Angeles, will speak on "Otology in Orbit."

**Ohio Psychiatric Association and Central Ohio Neuropsychiatric Society:** Columbus Plaza Hotel, 50 North Third Street, Mars Room, Second Floor, 6 P. M., social hour and dinner; 8 P. M., Dr. Roy R. Grinker, Sr., Chicago, will speak on "Depression and Normality: Psychosomatic Aspects."

**Jefferson Medical Alumni Reunion:** University Club of Columbus, 40 South Third Street, fellowship hour at 6 P. M., followed by dinner at 7 P. M.

## FRIDAY, MAY 14

**Section on Psychiatry and Neurology and the Ohio Psychiatric Association:** Columbus Plaza Hotel, 50 North Third Street, Venus Room, Second Floor, 12 Noon, luncheon. Following the luncheon, Dr. Robert S. Daniels, Chicago, will speak on "Community Psychiatry — A New Profession, A Developing Sub-Specialty or Effective Clinical Psychiatry."

**Ohio Chapter, American Academy of Pediatrics, Central Ohio Pediatric Society and OSMA Section on Pediatrics:** Columbus Plaza Hotel, 50 North Third Street, Venus Room, Second Floor, 6:30 P. M., social hour and dinner.

**Ohio Society of Pathologists:** Jai Lai Restaurant, 1421 Olentangy River Road, 7 P. M., dinner.

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## Woman's Auxiliary Meeting At Christopher Inn

The Woman's Auxiliary to the Ohio State Medical Association will meet in Columbus the week of the OSMA Annual Meeting. Most of the Auxiliary functions will be at the Christopher Inn, 300 East Broad Street in downtown Columbus.

Mrs. John D. Dickie, Toledo, will preside as president of the Auxiliary, and Mrs. Herbert Van

(Continued on Next Page)

# Separate Events of Special Groups (Contd.)

Epps, of Dover, will be installed as president for the coming year.

Details of the Auxiliary meeting will be published in the next issue of *The Journal*. Mrs. H. I. Humphrey, 389 So. Drexel Avenue, Columbus, is in charge of local arrangements.

\* \* \*

## **SATURDAY, MAY 15**

8:30 A.M. to 12:00 Noon

### **AMERICAN ACADEMY OF PEDIATRICS OHIO CHAPTER**

Auditorium, Third Floor  
Columbus Plaza Hotel

**Presiding:** Thomas E. Shaffer, M. D., Chairman,  
Ohio Chapter, American Academy of Pediatrics.

8:30 A. M. Business Session, Ohio Chapter,  
American Academy of Pediatrics.

#### **Seminar on Immunization**

Provided through Public Health Service Communicable Disease Center Seminar Services Program.

9:00 **Measles Vaccines**—Saul Krugman, M. D.,  
New York, N. Y., Chairman, Department of  
Pediatrics, New York University Medical Center.

9:30 **Laboratory Surveillance and Immunological Studies of Infectious Diseases**—Kenneth L. Herrmann, M. D., Atlanta, Ga., Chief, Virus Reference Unit Laboratory Branch, Communicable Disease Center.

10:00 Break.

10:15 **Rabies Vaccines**—John P. Fox, M. D.,  
Ph. D., New York, N. Y., Chief, Division of  
Epidemiology, Public Health Research Institute  
of New York City, Inc.

10:45 **Use and Abuse of Gamma Globulin**—  
Saul Krugman, M. D.

11:10 **Question and Discussion Period**—Henry G. Cramblett, M. D., Moderator, Columbus, Professor, Department of Pediatrics, College of Medicine, The Ohio State University.

**Resource Panel:** Saul Krugman, M. D.,  
Kenneth L. Herrmann, M. D., John P. Fox, M. D.,  
Ph. D.

12:00 Noon. Adjournment.

At the request of the Committee on Medical Aspects of Sports, the American Medical Association Board of Trustees has appointed the Subcommittee on Classification of Sports Injuries which is undertaking development of a standard nomenclature of sports injuries.

## **Information Booth**

The Academy of Medicine of Columbus and Franklin County will maintain an information booth for convenience of members during the OSMA Annual Meeting. The booth will be near the Registration Desk during hours that meetings are being held at the auditorium. The name of a physician called will be placed on a bulletin board near the booth. Physicians, therefore, are advised to consult this board from time to time.

## **Dependents' Medical Care Claims Paid in Ohio**

A report from Mutual of Omaha, administrative agency for the Dependents' Medical Care Program, shows that 13,385 claims from Ohio physicians for \$969,552.26 were paid last year out of the program's funds. This amount makes a grand total of payments since January 15, 1957 of \$8,020,971.58, representing 105,711 claims.

The Dependents' Medical Care Program is for the benefit of dependents of persons in military service who are away from military facilities and who are authorized to receive medical care under the program.

## **OSU Medical Alumni Plans AMA Meeting Reception**

The Ohio State University College of Medicine Alumni organization has made arrangements for a reception in New York City during the 1965 Annual Convention of the American Medical Association. The reception will be held in the Monte Carlo Suite of the Americana Hotel from 4:00 to 10:00 p. m. on Tuesday, June 22.

Dr. Richard L. Meiling, dean of the College of Medicine, and a member of the House of Delegates of the AMA, is planning to be present from 5:00 to 6:00 p. m.

## **Toledo Poison Information Center Moved to Maumee Hospital**

The Toledo Poison Information Center has been moved to the Maumee Valley Hospital, 2025 Arlington Avenue, Toledo, where the telephone number is EV 2-3435. The roster of Poison Information Centers in Ohio which appears as a regular feature in *The Journal* has been corrected to show this change. Persons who have clipped this roster and posted it for ready reference will want to note the new address and telephone number.

Mr. Darryl Zellers is in charge of the center and Dr. Marian M. Rejent, remains as director.



## SCIENTIFIC AND EDUCATIONAL EXHIBIT

The Scientific and Educational Exhibit will be open from 12 Noon to 5:30 P. M. on Tuesday, May 11; from 9:00 A. M. to 5:30 P. M., Wednesday and Thursday, May 12 and 13, and from 9:00 A. M. to 2:00 P. M. on Friday, May 14, Eastern Standard Time.

Following is a list of Scientific and Educational Exhibit applications which had been reviewed and approved by the Committee on Scientific and Educational Exhibit on or before January 30. Additional exhibits will be listed in the official program distributed at the meeting.

### Food and Gastrointestinal Disorders

American Medical Association, Department of Foods and Nutrition, Chicago, Ill.

### Mechanical Support for the Failing Heart

John H. Kennedy, M.D., Nicholas Bailas, M.D., A. J. Beyer, B.S., N. Sarap, B.S., Western Reserve University and Cleveland Metropolitan General Hospital, Cleveland.

### Toxemia, A Primary Cause of Maternal Deaths in Ohio

Committee on Maternal Health, Ohio State Medical Association.

### Phenylketonuria

Committee on Laboratory Medicine, Ohio State Medical Association, and The Maternal and Child Health Unit, Ohio Department of Health.

### Medicine and Religion

Committee on Medicine and Religion, Ohio State Medical Association.

### Safeguarding the Health of Athletes

Joint Advisory Committee on Athletic Injuries of the Ohio State Medical Association and the Ohio High School Athletic Association.

### Physician Placement Service

American Medical Association, Chicago, Ill.

### Pitfalls in Cancer Management

The American Cancer Society, Ohio Division, Inc., Cleveland.

### Pulmonary Embolism Diagnostic Testing Unit

Ohio State Heart Association, Columbus.

### Small Industry: An Opportunity for the Family Physician

American Medical Association, Chicago, Ill.

### Maple Syrup Urine Disease

Derrick Lonsdale, M.D., and W. R. Faulkner, M.D., Cleveland Clinic Foundation, Cleveland.

### Bedside Pulmonary Function Testing

Deane Hillsman, M.D., W. Robert Biddlestone, M.D., H. S. Van Ordstrand, M.D., Cleveland Clinic, Cleveland.

### Mammography in the Community Hospital

E. C. Baker, M.D., and Associates, B. C. Berg, M.D., F. A. Miller, M.D., Radiology Department, South Unit, Youngstown Hospital Association, Youngstown.

### Lymphangiographic Evaluation of Lymphatic Flow and Lymphedema

Edward Buonocore, M.D., Jess R. Young, M.D., Victor G. deWolfe, M.D., Edwin G. Beven, M.D., Cleveland Clinic Foundation, Cleveland.

### Ulcerative Colitis in Children

William M. Michener, M.D., Richard G. Farmer, M.D., Charles H. Brown, M.D., Cleveland Clinic Foundation, Cleveland.

### If Disaster Strikes and There Is No Doctor

Health Mobilization Unit, Ohio Department of Health.

### A Postoperative Aid to the Reduction of Urinary Retention

Martin E. Felder, M.D., Richard P. Dickey, M.D., William Copeland, M.D., Ohio State University Hospital, Columbus.

### Lumbar Discography: A Twelve Year Experience

John S. Collis, Jr., M.D., W. James Garner, M.D., Thomas M. Tank, M.D., Cleveland Clinic, Cleveland.

### Bio-Assay of Steroids for Topical Application

Richard B. Stoughton, M.D., Western Reserve University School of Medicine.

### The Diagnosis and Management of Pheochromocytoma

John H. Wulsin, M.D., Thomas E. Gaffney, M.D., University of Cincinnati College of Medicine, Cincinnati.

(More Scientific Exhibits on Next Page)

## SCIENTIFIC AND EDUCATIONAL EXHIBIT (Continued)

### Differential Diagnosis of Syphilis

Ohio Department of Health, Venereal Disease  
Control and U.S. Public Health Service,  
Columbus.

### The Practicality and Need for an Artificial Kidney in Non-University Hospitals

Warren W. Smith, M.D., W. Bergen, M.D.,  
John F. Condon, M.D., Columbus Medical  
Center and Riverside Methodist Hospital,  
Columbus.

### Diabetic Acidosis, Programmed Instruction for a Community Hospital

Leonard P. Caccamo, M.D., St. Elizabeth Hos-  
pital, Youngstown.

### Thoracic Aneurysms

John Storer, M.D., E. A. Husni, M.D., Huron  
Road Hospital, Cleveland.

### Needle Biopsy of Thyroid

William A. Hawk, M.D., J. B. Hazard, M.D.,  
George W. Crile, Jr., M.D., David L. Bar-  
rett, M.D., Cleveland Clinic Foundation,  
Cleveland.

### Clinicopathologic Spectrum of Cutaneous Lupus Erythematosus

W. A. Hawk, M.D., K. H. Burdick, M.D.,  
Faye A. Rundell, M.D., J. R. Haserick, M.D.,  
Cleveland Clinic Foundation, Cleveland.

### Vocational Rehabilitation in Ohio

Ohio Bureau of Vocational Rehabilitation,  
Columbus.

### Delivery Force: Traction and Compression Forces Exerted by Obstetrical Forceps and Their Effect on Fetal Heart Rate

John C. Ullery, M.D., N. J. Teteris, M.D.,  
Andrew W. Botschner, M.D., Betty A. Mc-  
Daniels, Department of Obstetrics and Gyne-  
cology, Ohio State University, Columbus.

### Alcoholism Theatre

OSMA Committee on Mental Health and Ameri-  
can Medical Association, Chicago.

### Center of Science and Industry

Center of Science and Industry, Columbus.

### Changed Your Address? If So, Send the New One to Us Promptly

If you have moved, you will want *The Journal* and other OSMA mail sent to your new address. Please complete the coupon and mail it to us immediately since it takes several weeks to have new stencils made for the mailing list.

The Ohio State Medical Association  
79 E. State Street, Room 1005  
Columbus, Ohio 43215

#### Notice of Change of Address

NAME (print) .....

OFFICE ADDRESS .....

Street

City

Zip code

TELEPHONE .....

HOME ADDRESS .....

Street

City

Zip code

TELEPHONE .....

SEND MAIL TO ☐ Office address ☐ Home address



## TECHNICAL EXHIBITORS

**EXHIBIT HALL, VETERANS MEMORIAL BUILDING, 300 W. BROAD ST., COLUMBUS, OHIO**

**Open from 12:00 Noon to 5:30 P. M., Tuesday, May 11; from 9:00 A. M. to 5:30 P. M. on Wednesday and Thursday, May 12 and 13; and from 9:00 A. M. to 2:00 P. M. on Friday, May 14.**

Exhibitor	Address	Booth No.	Exhibitor	Address	Booth No.
Abbott Laboratories, North Chicago, Ill. ....		40	Loma Linda Foods, Riverside, California .....		41
Allergy Laboratories of Ohio, Inc., Columbus, Ohio .....		36	Mead Johnson Laboratories, Evansville, Ind. ....		11
Aloe, Division of Brunswick, St. Louis, Mo. ....		43	Medco Products Co., Inc., Tulsa, Oklahoma .....		18
Americana Corporation, Beverly Hills, California		48	The Medical Protective Co., Fort Wayne, Ind. ....		38
Ames Company, Inc., Elkhart, Indiana .....		60	Merck Sharp & Dohme, West Point, Pa. ....		67
Arnar-Stone Laboratories, Inc., Mount Prospect, Ill. ....		35	The Wm. S. Merrell Company, Cincinnati, Ohio		1
Astra Pharmaceutical Products, Inc., Worcester, Mass. ....		72	The National Drug Company, Philadelphia, Pa.		12
Audio-Digest Foundation, Pacific Medical Equipment Co., North Hollywood, Calif. ....		62	Ohio Bell Telephone Company, Cleveland, Ohio		7
Ayerst Laboratories, Chicago, Ill. ....	63 &	71	Ohio Medical Indemnity, Inc., Columbus, Ohio .....		44
Baker Laboratories, Inc., East Troy, Wisconsin..		29	Ohio State Society of Medical Assistants .....		55
Berkeley Medical Instruments, Berkeley, Calif....		50	Ortho Pharmaceutical Corp., Raritan, N. J. ....		5
Beverage Management, Inc., 7 Up, Columbus, Ohio .....		64	Pacific Medical Equipment Co., North Hollywood, California .....		62
Bowman, Inc., Canton, Ohio .....		9	Parke, Davis & Company, Detroit, Mich. ....		80
Breon Laboratories, Inc., New York, N. Y. ....		8	Pfizer Laboratories, New York, N. Y. ....		75
Brewer & Company, Inc., Worcester, Mass. ....		30	Philips Roxane Laboratories, Columbus, Ohio ....		21
Burroughs Wellcome & Co., (U.S.A.) Inc., Tuckahoe, N. Y. ....		70	Professional Building & Equipment Co., Mansfield, Ohio .....		59
Cameron-Miller Surgical Instruments Co., Chicago, Ill. ....		24	Roche Laboratories, Nutley, N. J. ....		10
S. H. Camp & Company, Jackson, Michigan .....		46	J. B. Roerig & Company, New York, N. Y. ....		14
Ciba Pharmaceutical Company, Summit, N. J. ....		51	Ross Laboratories, Columbus, Ohio .....		2
The Coca-Cola Company, Atlanta, Ga. ....		85	Royal Crown Bottlers Association of Ohio, Dayton, Ohio .....		27
Cutter Laboratories, Berkeley, California .....		53	Sanborn Company, Cleveland, Ohio .....		34
Daniels-Head & Associates, Inc., Portsmouth, Ohio .....		31	Sandoz Pharmaceuticals, Hanover, N. J. ....		54
Dome Chemicals Inc., New York, N. Y. ....		33	W. B. Saunders Company, Philadelphia, Pa. ....		76
The Doyle Pharmaceutical Co., Div. of The Dietene Co., Minneapolis, Minn. ....		77	G. D. Searle & Co., Chicago, Ill. ....		87
The Emko Company, St. Louis, Mo. ....		19	Smith Kline & French Laboratories, Philadelphia, Pa. ....		61
Encyclopaedia Britannica, Chicago, Ill. ....		73	Smith, Miller & Patch, Inc., New York, N. Y. ....		81
Fuller Pharmaceutical Co., Minneapolis, Minn.		32	Spray Lin, Inc., Cleveland, Ohio .....		82
Geigy Pharmaceuticals, Yonkers, N. Y. ....		42	Stiefel Laboratories, Inc., Oak Hill, N. Y. ....		69
Gerber Products Company, Fremont, Michigan..		17	E. R. Squibb & Sons, New York, N. Y. ....		65
Great Books of the Western World, Chicago, Ill.		66	Syntex Laboratories, Inc., Palo Alto, California .....	47 &	83
H. J. Heinz Company, Pittsburgh, Pa. ....		25	Turner & Shepard, Inc., Columbus, Ohio .....		22
Huntington National Bank of Columbus, Columbus, Ohio .....		58	S. J. Tutag & Company, Detroit, Mich. ....		26
Jobst Institute, Inc., Toledo, Ohio .....		52	The Upjohn Company, Kalamazoo, Mich. ....		56
Johnson & Johnson, New Brunswick, N. J. ....		6	U. S. Vitamin & Pharmaceutical Corp., New York, N. Y. ....		3
Lederle Laboratories, Pearl River, N. Y. ....		16	Vercor & Company, Columbus, Ohio .....		84
Eli Lilly and Company, Indianapolis, Ind. ....		39	Wallace Laboratories, Cranbury, N. J. ....		49
J. B. Lippincott Company, Philadelphia, Pa. ....		23	Warren-Teed Pharmaceuticals Inc., Columbus, Ohio .....		45
Lloyd Brothers, Inc., Cincinnati, Ohio .....		4	The Wendt-Bristol Co., Columbus, Ohio .....		37
			Westwood Pharmaceuticals, Buffalo, N. Y. ....		57
			Winthrop Laboratories, New York, N. Y. ....		28
			The Max Woche & Son Co., Cincinnati, Ohio....		79

# County Society Officers Back Eldercare

## AMA's Eldercare Program Is Explained at Called Meeting In Columbus; Public Education Campaign Launched in Ohio

A SPONTANEOUS RESOLUTION presented at the called meeting of County Medical Society Officers and key committee chairmen in Columbus was passed by acclamation and in effect pledged united support in Ohio for the AMA-sponsored Eldercare program, known in Congress as H. R. 3727. The resolution reads as follows:

"BE IT HEREBY RESOLVED, That the assembled officers and members of County Medical Societies approve the program known as 'Eldercare,' thereby pledging all efforts necessary to obtain passage of H. R. 3727."

The special meeting was called following the emergency meeting of the American Medical Association House of Delegates in Chicago, February 6 and 7. The AMA House of Delegates met to take definite action in support of Eldercare in contrast to the administration's Medicare program.

### Washington Office Speaker

At the Columbus meeting on February 13, guest speaker was Paul R. M. Donelan, LL. B., legislative attorney in the Washington office of the American Medical Association, who explained the various points of contrast between the administration's Eldercare program (H. R. 3727) and the administration's Medicare program (H. R. 1).

There is time to influence Congress in regard to these two bills, Mr. Donelan emphasized, stating that Congressmen are most influenced by individual comments from their constituents back home.

### The Campaign in Ohio

"Campaign Suggestions for County Medical Societies," was the topic of a talk by Charles W. Edgar, director of public relations for the Ohio State Medical Association. Following is a gist of what is being done in Ohio and what can be done to further the medical profession's stand:

1. Advertisements have been placed by the Ohio State Medical Association in all daily and weekly newspapers in Ohio. The advertisements will appear for three consecutive weeks. (See facing page for copy of one of these ads.)

2. The County Medical Society is requested to contact as many organizations as possible to solicit their support in the campaign. Physicians should

ask the support of organizations in which they hold membership.

These organizations should be asked to go on record in support of Eldercare H. R. 3727, and in opposition to Medicare, H. R. 1. Request their members to write personal letters to their Senators and Congressman in support of the Eldercare Bill.

3. County Societies are asked to urge their individual members to write to their Congressman and Senators, and to urge their relatives and friends to do likewise.

4. The *OSMAgram*, recently mailed to every member, included among other materials, two copies of a resolution urging support of Eldercare. Physicians should keep this resolution on their desk, ask their patients to sign it, and mail the resolution to their Congressman as soon as it is filled with names.

5. It is recommended that each Society organize a select committee to call on newspaper editors and radio and television news directors in the county to present the facts regarding these two bills. Experience has shown that this is a very productive step for it has been very successful in making the news media understand medicine's position. In many instances, it has resulted in media support of that position.

6. Each county society is being provided with a set of speeches. A speakers bureau is a highly effective means of presenting medicine's story and enlisting support. The speakers bureau should be ready to present a speaker before any group so requesting one, and should be prepared to provide a speaker on short notice.

7. It is strongly suggested that the County Medical Society organize a committee to call on the Congressman from the District in which the Society is located. This committee, if possible, should consist of well-informed physicians known to the Congressman.

8. It is recommended that the Woman's Auxiliary and the Medical Assistants be utilized to the greatest extent. Both the OSMA Auxiliary and the Ohio State Society of Medical Assistants have repeatedly volunteered to accept any and all assignments in this important campaign.

These two groups, on the county level, should be asked to organize their own letter-writing campaigns,

*(Continued on Page 276)*



# ELDERCARE

. . . better care than Medicare

•

Here's why the Herlong-Curtis Eldercare Bill, HR 3727, is the best answer to the health care needs of people over 65

## MORE BENEFITS FOR THE ELDERLY

Eldercare would provide a wide range of hospital and medical services for the elderly — much more than Medicare.

	ELDERCARE	MEDICARE
Physicians' Care	YES	NO
Surgical Costs	YES	NO
Drugs — In and out of Hospital	YES	NO
Hospital and Nursing Home Charges	YES	YES

## LESS COST TO THE TAXPAYERS

Eldercare offers **more** care for the elderly who need help, but would **cost less** because it does not provide benefits for the wealthy and well-to-do. Eldercare would **not** require a new payroll tax. It would be financed by federal-state funds through a program that **already** exists.

By contrast, the Medicare tax plan would increase payroll taxes to provide benefits for **everyone** over 65, the wealthy included. Furthermore, the Medicare tax would hit hardest those least able to pay. The \$5,600-a-year worker would pay as much tax as the \$56,000 executive.

Your doctors, who care for the elderly, support Eldercare because it also assures free choice of physician and hospital . . . provides for protection through Blue Cross, Blue Shield and health insurance policies . . . and lets people over 65 qualify for benefits before illness strikes — without a welfare type investigation.

*Write Today!*

Urge **YOUR** congressman and senators to vote for Eldercare

(The Herlong-Curtis Bill, H. R. 3727)

(Local) County Medical Society

The above notice appeared three times in all daily and weekly newspapers in Ohio. Signature was that of the County Medical Society or the State Association.

to obtain speaking engagements for members of the speakers bureau, and to enlist the support of the many organizations in which they hold membership. These two groups have voluntarily offered to carry out any assignment given them.

9. It is recommended that a Councilor District committee, consisting of the Councilor as chairman and the County Society presidents as members, be organized to meet weekly to review what is being done in the district, to exchange information and ideas.

10. Requests for materials and information may be telephoned to OSMA Headquarters. Telephone requests are suggested to avoid delay.

11. It is suggested that County Medical Societies consider purchasing radio and television time to air spot announcements. The state office will give assistance in preparing the spots.

**NOTE:** Little publicity has been given to the heavy increase in the Social Security tax rate that would result from passage of H. R. 1. More emphasis should be put on this increase. Very few persons realize the extent of the tax jump.

#### President Urges Action

Dr. Robert E. Tschantz, Canton, OSMA President and an Alternate Delegate to the AMA House of Delegates, described the actions taken at the special session of the AMA House of Delegates in Chicago, and urged concerted effort on the part of all County Medical Societies in Ohio. His talk was entitled "The Ohio Eldercare-Medicare Campaign."

Officers and key committee chairmen from most of the County Medical Societies attended the February 13 special meeting in Columbus. Those invited to the conference were officers of County Medical Societies, and chairmen of committees on public relations and legislation; also officers and directors of the Woman's Auxiliary to the OSMA and key persons in the Ohio State Society of Medical Assistants.

Dr. Henry A. Crawford, Cleveland, President-Elect of the State Association, presided at the meeting, which followed a complimentary luncheon served in the Pick-Fort Hayes Hotel by the Association. Approximately 125 persons attended the meeting.

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Three physicians were among the top 10 men of 1964 named by the Columbus area Junior Chamber of Commerce. They are Dr. Henry Habib, Dr. Robert Murphy and Dr. James Bailey.

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The Cook County Graduate School of Medicine, 707 So. Wood St., Chicago, will hold a two-week intensive education course in the Neuromuscular Diseases of Children with Special Emphasis on Management, June 7-18.

## Hospitals Invited to Apply Now for OSU Medical Education Network

Deadline for applications from hospitals wanting to participate in the Ohio Medical Education Network for 1965-66 is May 31.

Robert B. Schweikart, who directs OMEN for the Ohio State University College of Medicine, says 43 hospitals are currently enrolled in the two-way radio-telephone network. The network links faculty of the College of Medicine with hospital medical staffs for noontime programs. Following lectures, listening physicians have a question and answer period with the speakers via telephone.

Medical programs are broadcast by 11 FM radio stations. A maximum of 12 hospitals are included in one day's program, to insure ample time for questions. Currently, the same program is broadcast four days each week.

OMEN programs originate with WOSU-FM, which transmits on network lines to the other stations.

Applications may be made to the Ohio State University College of Medicine, Center for Continuing Medical Education, 1645 Neil Ave., Columbus, Ohio 43210.

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#### Guidelines Are Published On Oral Polio Vaccine

New recommendations on the use of oral polio vaccine were announced by the American Academy of Pediatrics, following a report of the advisory committee to the U.S. Public Health Service Surgeon General (*The AMA News*, Oct. 12, 1964).

The AAP's Committee on the Control of Infectious Diseases recommended the use of trivalent oral polio vaccine for infants; earlier, it had recommended its use only for older children and adults.

The recommended schedule for infants is three doses of trivalent vaccine at six to eight week intervals, with a fourth dose a year later. For older children and adults, the schedule is two doses six to eight weeks apart.

The committee concurred with the PHS recommendation that oral vaccine be given only to persons under 18 years of age, except in unusual circumstances.

Copies of the AAP recommendations may be had by writing the American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill.

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The Veterans Administration announced that a new scientific journal, *The Pavlovian Journal for Research*, will be published especially for psychologists and psychiatrists, from the Perry Point Research laboratory at Johns Hopkins Medical School. It will be the official journal of the Pavlovian Society of America, founded in 1953. Dr. W. Horsley Gantt, president of the society, will be editor-in-chief.



# AMA Acts on Health Care...

## Ohio's Proposed Standards for Health Care Programs Among Measures Adopted at Chicago Special Session

**M**EETING in a two-day special session in Chicago to review current health care legislation, the House of Delegates of the American Medical Association gave unanimous approval and support to the AMA Eldercare Program and to the Herlong-Curtis Eldercare bill (H. R. 3727), which embodies the basic principles of the AMA program.

In acting upon six resolutions and reports from the AMA Board of Trustees, Council on Legislative Activities and Council on Medical Service, the House of Delegates also:

1. Reaffirmed its opposition to the King-Anderson bill (H. R. 1 and S. 1) and all similar measures;

2. Commended the Board of Trustees and its Task Force for implementing and funding a program of public education on the AMA Eldercare Program and gave them a standing vote of confidence;

3. Called for study of the "desirability and feasibility of extending the principle of federal and state aid under the Kerr-Mills principle to persons below the age of 65 who need help";

4. Adopted a statement on Standards for Health Care Programs, submitted by the Ohio delegation as the result of a resolution of the OSMA Council January 31, and,

5. Urged that the professional services of pathologists, radiologists, psychiatrists and anesthesiologists should be excluded from the provisions of any bill which excludes other physicians' services.

### Ohio Delegation

The Ohio State Medical Association was represented in Chicago at the AMA House of Delegates by the following persons: Dr. George W. Petznick, Cleveland; Dr. Carl A. Lincke, Carrollton; Dr. Theodore L. Light, Dayton; Dr. Edmond K. Yantes, Wilmington; Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Paul F. Orr, Perrysburg; Dr. Charles A. Sebastian, Cincinnati; and Dr. Edwin H. Artman, Chillicothe.

Also attending sessions of the House of Delegates were Dr. Frederick P. Osgood, Toledo, alternate delegate; Dr. Robert E. Tschantz, Canton, President of OSMA and an alternate AMA delegate; Dr. Henry A. Crawford, Cleveland, OSMA President-Elect; and Messrs. Hart F. Page, Executive Secretary of OSMA; and Charles W. Edgar, OSMA Public Relations Director. Also among Ohioans was Robert A. Lang, Executive Secretary of the Academy of Medicine of Cleveland.

### AMA Eldercare Program

First announced on January 9 by AMA President Donovan F. Ward, at the Association's Kerr-Mills Conference in Chicago, the AMA Eldercare Program would encourage the use of voluntary health insurance or prepayment plans in the implementation of Kerr-Mills programs, permit the state to have a health-oriented agency supervise or administer the program, provide for use of an income information statement as the sole eligibility test of need, and provide for a wide spectrum of medical, surgical and hospital benefits with sliding-scale eligibility so that a citizen 65 and over would pay all, part or none of the cost of the insurance or prepayment policy, depending on his income.

### The Eldercare Bill

These principles are incorporated in the Eldercare Act of 1965, introduced on January 27 by Representatives A. Sydney Herlong, Jr., (D., Fla.), and Thomas B. Curtis (R., Mo.), amending the Kerr-Mills law to authorize broad health insurance coverage for elderly persons.

The Herlong-Curtis bill would authorize federal grants to the states on a matching basis to help persons 65 years of age and older pay the costs of the health insurance or prepayment policy if they could not afford it otherwise. The bill would provide for utilization of Blue Shield and Blue Cross plans and private health insurance companies.

The cost of such coverage would be borne entirely by government for those elderly individuals whose income falls below limits set by each state. For individuals with incomes between the minimum and a maximum, government would pay a part of the cost on a sliding scale according to income. Individuals with income above the maximum would pay the entire cost, but they would have the benefits of an income tax deduction for such payments.

Persons under 65 years of age also would be given an income tax deduction for the amount of premiums paid on health insurance policies for elderly relatives.

### Dr. Ward's Address

Condemning the King-Anderson bill and urging support of the Eldercare program, Dr. Ward told the House on the first day of the Special Session:

"Are 200,000 doctors wrong in urging the Congress to give serious consideration to the one measure now before it that offers genuine medical and hospital benefits to the needy aged? This is a bill

authored neither by the Republican party nor the Democratic party. It is a bill with bipartisan parentage — the Herlong-Curtis Eldercare bill, numbered H. R. 3727. We urge Congress to compare, and the people to compare, this bill with its genuine benefits and realistic financing — and with its provision allowing for administering a health program through health agencies of the states — to compare it feature-by-feature with Medicare.

"If the drums can be stilled long enough to make this comparison, it will be found that the Herlong-Curtis Eldercare bill can cover not only the cost of hospital care and nursing homes for the aged, but also payment of physicians and surgical and drug costs — which Medicare would not do."

Dr. Ward declared that "it is never too late to pass good legislation and defeat bad legislation. The one thing in this historic decision — the only thing — that may truly come too late, is regret."

### Education Program

Dr. Percy E. Hopkins, Chairman of the Board of Trustees, reported to the House that the AMA's current effort to tell its story to the people and to the Congress is being financed through the allocation of a portion of the Association's reserve fund. In response to a number of questions raised during the open discussions, the delegates also were told that the education program will not require a dues increase or a special assessment. The program will be national in scope — involving magazines, radio and television — but maximum grass roots effort was urged upon the entire AMA membership and the Woman's Auxiliaries.

### Health Care Legislation

Declaring that "it is essential that the position of the AMA be made clearly apparent while at the same time remaining responsive and flexible in legislative developments," the House passed a resolution reaffirming earlier positions established on federal medical care programs.

Specifically included was the reaffirmation of the policy established by the House of Delegates at the 1964 Clinical Convention, which urged component associations to stimulate state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care is available.

The House defeated a motion that "a medical and hospital service plan with minimum benefits specified, one and the same across the nation from the point of view of the benefits offered, be prepared to accompany H. R. 3727" (the Herlong-Curtis Eldercare bill).

The House tabled that portion of the Reference Committee on Legislation and Public Relations Report dealing with Resolutions No. 3 and No. 5, both

of which called for the AMA to propose legislation which would extend health insurance coverage to all needy persons regardless of age.

In considering this proposal, the House adopted Resolution No. 7, introduced by California, one portion of which asked that "the AMA Board of Trustees, the Council on Medical Service and the Council on Legislative Activities (a) study the desirability and feasibility of extending the principle of federal and state aid under the Kerr-Mills principle to persons below the age of 65 who need help and (b) report their recommendations as early as possible to the AMA Board of Trustees and House of Delegates as a basis for formulation of future AMA policy in this regard."

After adopting the California resolution, the House voted not to "lift from the table" the portion of the Reference Committee Report dealing with Resolutions No. 3 (Indiana) and No. 5 (Michigan).

### Ohio's Statement on Standards For Health Care Program

The House adopted the following principles as submitted by the Ohio delegation as essential to sound health care programs:

1. No person needing health care shall be denied such care because of inability to pay for it.
2. It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.
3. Every level of government (municipal, county, state and federal) should assume a responsible share in the financing of such programs.
4. The health care provided by such programs should be adequate and should be equal in quality to that available to those who can afford to pay.
5. Maximum use should be made of voluntary prepayment and insurance mechanisms.
6. Administration of such a program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.
7. Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.
8. Any such health care program should provide funds only, and not direct services.
9. Funds for such programs should come from general tax revenues and not from Social Security taxes.

### Medical Service Report

In approving the report of the Council on Medical Service, the House adopted the following statement:

"The Council believes it is important for the profession to note that, while suggested mechanisms for providing health care to the needy have changed as the nation's social and economic structure has changed, the basic underlying concepts of the American Medical Association, upon which our policy statements have been made, have not changed."



# OSMA Executive Appointments...

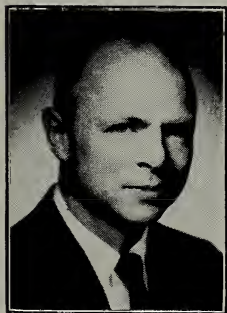
## Full Status Is Given in Executive Secretary Post As The Council Affirms Two Top Staff Positions

THE COUNCIL of the Ohio State Medical Association at a meeting on January 31, named Hart F. Page to full status as Executive Secretary of the Association, after previously appointing him Acting Executive Secretary at the December meeting. At the same time The Council also named Charles W. Edgar as Assistant Executive Secretary and Director of Public Relations, both of which posts he held on an acting basis since the December meeting.

### Executive Secretary

Mr. Page was named Executive Secretary after 19 years of service with the Association, having joined the executive staff in 1946, following military service during World War II. He has served successively as

Assistant Director of Public Relations, Director of Public Relations and Assistant Executive Secretary, then Acting Executive Secretary, before his recent appointment to full status as Executive Secretary. As the Association's chief administrative officer, Mr. Page works under direction of The Council.



Hart F. Page

During his tenure, Mr. Page has been engaged directly or indirectly in virtually every phase of the Association's programs and activities. He has been secretary of many of the OSMA committees; has maintained close liaison with County Medical Societies and has been guest speaker at a number of local meetings; has worked both in planning and in carrying out details for OSMA Annual Meetings, County Medical Society Offices Conferences, and other organization functions.

### Liaison Activities

In liaison functions with other organizations, Mr. Page has attended numerous meetings and informal discussion groups with groups that have an interest in medicine or health, including many governmental agencies.

In addition to his other duties, he was News Editor of *The Journal* before a full-time staff member

was engaged for that function. He has been a consistent contributor to *The Journal* with articles and news items.

One of his important functions has been close liaison with members of the Ohio General Assembly, especially during Legislative sessions. Members of the Legislature have been offered the services of the Association when information pertaining to medical or health subjects have been needed. Close liaison with governmental agencies interested in medical and health matters also has been maintained.

The OSMA has an important function as a constituent of the American Medical Association. Mr. Page for many years has accompanied the Ohio delegation to AMA Conventions and kept contact with the AMA headquarters in Chicago.

Among activities closely related to his work, he is a member of the Board of Directors of the Ohio Trade Association Executives, member of the Medical Society Executives Association, member of the Professional Convention Managers Association, and a past-chairman of the State Planning Committee for Health Education in Ohio; also a member of the Joint Advisory Committee on Athletic Injuries (OSMA and Ohio State High School Athletic Association, and a past-president of the Columbus Chapter, Public Relations Society of America.

### Early Experiences

A native of Tuscarawas County, Mr. Page graduated from Midvale High School and attended Ohio State University where he received a B. Sc. degree in Journalism in 1938. Before the war, he was associated with the Ohio State Grange as director of public relations and legislative representative; also associate editor and business manager of the *Ohio State Grange Monthly*. During much of the same period he was director of public relations for the Columbus Junior Chamber of Commerce on a voluntary basis.

During World War II he served as a lieutenant in the U. S. Navy. On duty in the Pacific theater, he was assistant boat group commander on the *U. S. S. Sarita (AKA 39)*. He is a member of the University Club, the United States Squash Racquets Association, a member of Sigma Delta Chi, journalism fraternity, and former secretary of the Central Ohio

Professional Chapter of SDX; also a member of the Presbyterian Church.

Mr. and Mrs. Page have four children: Martha Ann, a student at Muskingum College; Susan, a student at North High School in Columbus; William Richard, age 11; and Judith Margaret, age 7.

### Director of Public Relations Has Extensive Background

Charles W. Edgar, now Director of Public Relations and Assistant Executive Secretary, has been on the administrative staff of the Association since August, 1956. He came into medical organization work with an extensive background in newspaper writing and editing.

Mr. Edgar has worked extensively as secretary of various committees of the Association. As former secretary of the Committee on Rural Health, he helped members of the committee set up the "When

You Begin Practice" lectures for medical students in Ohio's Medical Colleges. These have become annual events at Ohio State University College of Medicine and the University of Cincinnati College of Medicine, where medical school officials work closely with the Association to promote these programs.



Chas. W. Edgar

Another related activity is that of the Preceptorship

Program which he organized under direction of members of the Rural Health Committee. Under this program, medical students may elect to take a week or more of preceptorship with a practicing physician in a non-metropolitan area. He also worked with the committee to promote the Association's Medical Scholarship program, under which a medical student from a non-metropolitan area is financially aided through the four years of medical school. Two such scholarships are now awarded by the Association at the beginning of each school year.

### Other Activities

Other OSMA Committees with which he has worked as secretary include the Committees on Cancer, Laboratory Medicine and the OMI Special Study Committee. The latter committee was a special study group appointed at the direction of the House of Delegates.

He is presently secretary of the Committees on Education, Public Relations and Economics, Workmen's Compensation, Occupational Health, Joint Committee on Family Practice and the Committee on Care of the Aging.

In the recent educational campaign sponsored by the American Medical Association and the OSMA

to acquaint the public with the facts about health care aid for senior citizens, Mr. Edgar was in charge of the detail work in spreading this program statewide.

He also has worked extensively in legislative matters, offering the services of the Association to members of the Ohio General Assembly when medical or health information is needed; also in offering these services to personnel of the various State agencies dealing with medical and health matters.

A native of West Virginia, Mr. Edgar entered West Virginia University in 1939. His college work was interrupted by three years of service in the Army, after which he received a B.S. degree in Journalism in 1946. In college he was president of the Journaliers, men's professional journalism honorary fraternity. He was also active in the college press club, Phi Sigma Kappa, intramural sports and the men's glee club.

### Previous Honors

In each of two years as managing editor of the *Canandaigua* (N. Y.) *Messenger*, he was accorded the New York State Citizens' Public Expenditures Survey annual award for "editorial excellence and news coverage in the field of local government."

While in the editorial department of the *Canton* (Illinois) *Daily Ledger*, he helped organize the local chapter of the Junior Chamber of Commerce and was voted "Mr. Jaycee" by that organization. While on the editorial staff of the *Springfield* (Ohio) *Daily News*, he won the American Political Science Association Distinguished Reporting Award. In Springfield also he worked part time as administrative secretary for the Clark County Medical Society and helped that organization compile its history in printed form.

Mr. Edgar is a member of the Medical Society Executives Association, the Ohio Trade Association Executives, the University Club and the First Community Church. Mr. and Mrs. Edgar have two sons, Charles W., III, and Chris.

The office of Executive Secretary was filled on an acting basis at the December meeting of The Council when George H. Saville requested that he be put on a consultant status. His request was made on the advice of his physician following hospitalization, and brought to a climax a career of more than 30 years' service with the Association. Mr. and Mrs. Saville are now vacationing in Florida.

### American College of Physicians Nuclear Medicine Course

The American College of Physicians will present Postgraduate Course No. 12, entitled "Nuclear Medicine for the Internist," at Johns Hopkins Hospital, Baltimore, Md., April 5-9.

Among members of the faculty will be Dr. William G. Myers, biophysics research professor, at Ohio State University, Columbus.



# Proceedings of The Council...

## Report of January 31 Special Meeting, Called To Consider Current Health Care Proposals and Other Important Matters

A SPECIAL MEETING of The Council of the Ohio State Medical Association was held on Sunday, January 31, 1965, at the OSMA Headquarters Office, Columbus. All members of The Council were present. Others attending the meeting were: Drs. Frank H. Mayfield, Cincinnati, H. M. Platter, H. M. Clodfelter and George J. Hamwi, Columbus, Past-Presidents of the Association; Drs. John H. Budd, Cleveland, Richard L. Meiling, Columbus, Paul F. Orr, Perrysburg, Charles A. Sebastian, Cincinnati, George W. Petznick, Cleveland, Carl A. Lincke, Carrollton, Edmond K. Yantes, Wilmington, Frederick P. Osgood, Toledo, J. Robert Hudson, Cincinnati, Robert S. Martin, Zanesville, Delegates and Alternates to the American Medical Association; Mr. Wayne E. Stichter, Toledo, legal counsel; and Messrs. Page Edgar, Gillen, Taphagan and Moore, members of the OSMA staff.

### President's Remarks

President Tschantz reviewed recent events, including the meetings called by the American Medical Association, December 13 and January 9 and 10, and a conference on January 6 with Mr. Clarence V. Tittle, Chief of the Division of Aid for the Aged, Ohio Department of Welfare. Dr. Tschantz emphasized the urgency of action with regard to the problems which confront medicine.

### Minutes Approved

Minutes of the meeting of The Council held on December 12-13, 1964, were approved by official action.

### Membership Statistics

The following membership statistics were reported by Mr. Page: OSMA membership as of December 31, 1964, 9,933, compared to a total membership at the end of 1963 of 9,743. He reported that of the 9,933 OSMA members, 8,918 were affiliated with the AMA.

### Legislation

After considerable discussion on current legislation with regard to legislative proposals for care of the aging, The Council, on motion duly made, seconded and carried, voted to adopt the following resolution with regard to standards for health care programs and to submit the resolution at the February 6 and 7

special meeting of the American Medical Association House of Delegates:

### Policy on Health Care

BE IT RESOLVED, that the American Medical Association hereby adopts the following principles as essential to sound health care programs:

1. No person needing health care shall be denied such care because of inability to pay for it.

2. It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

3. Every level of government should assume a responsible share in the financing of such programs.

4. The health care provided by such programs should be adequate and should be equal in quality to that available to those who can afford to pay.

5. Maximum use should be made of voluntary prepayment mechanisms.

6. Administration of such a program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration and health care in order to qualify for Federal funds.

7. Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

8. Any such health care program should provide funds only, and not direct services.

9. Funds for such programs should come from general tax revenues and not from Social Security taxes.

The Council then voted to authorize the release of the following statement with regard to the Ohio State Medical Association's policy concerning legislation in this field:

"The Ohio State Medical Association continues to seek a method whereby all the people of this nation may prepay the cost of the medical care they need. It favors and supports methods whereby general tax funds are used to prepay the costs for those who are unable to pay for themselves. It has instructed its delegates to the AMA to support legislation that will accomplish these objectives.

"The Ohio State Medical Association opposes, however, the Medicare Bill now before the Con-

gress on the basis that it does not meet the health care needs of the people, and, because it imposes an unfair and disproportionate tax on the wage earner."

### OSMA Education Program

The Council voted to appropriate \$22,750 from the reserve funds of the Association to match a similar amount offered by the American Medical Association in order to implement an education program with regard to the provision of medical care to those who need help.

The Council voted to accept recommendations of the staff of the Association with regard to the operation of the education campaign. The recommendations covered the following areas:

1. That approximately \$37,500 of the \$45,500, made available under the OSMA-AMA matching program, be used to obtain newspaper space.

2. That the support of a select list of Ohio associations and organizations be obtained in the education program. It was recommended that each county medical society do the same on a county basis with regard to local organizations and associations.

3. That resolutions with regard to supporting the AMA program be provided for each member's office and that members be asked to write letters to their Congressmen. It was announced that literature would be provided for each member's office.

4. That the county society presidents, with the district councilor as chairman, form a committee in each councilor district to meet regularly to discuss matters with Congressmen.

5. Each society will be provided with new materials for its speakers bureau and the societies will be requested to reactivate such speakers bureaus.

6. It was recommended that each county medical society be urged to appoint a select committee to call upon local newspaper editors and all radio and television station managers.

7. That all county society presidents and the Operation Hometown, Ohio, Chairmen, be called into a statewide meeting for orientation on the program.

8. It was recommended that the Woman's Auxiliary of the State Society and the local auxiliaries, as well as the Ohio State Society of Medical Assistants, be fully utilized in the program.

9. Pocket-size cards with information concerning various medical care proposals are being prepared for members.

10. A film of Dr. Annis' television appearance is being purchased, with prints being made available to county medical societies at a cost of \$60.

11. County medical societies will be urged to appropriate money to obtain radio and television advertising space to provide information to the public.

The Council authorized the staff to employ tem-

porary clerical and stenographic help, if necessary, and to purchase from program funds additional materials if necessary.

### American Board of Family Practice

The Council then considered a resolution endorsing the formation of an American Board of Family Practice and supports its requests for approval and recognition by the American Medical Association. After considerable discussion, such resolution was adopted by a vote of 10 to 3.

On motion duly made, seconded and carried, The Council voted to support a proposed conference on family practice to be sponsored by the Ohio State Medical Association and the Ohio Academy of General Practice on February 21, 1965. In addition, The Council appropriated \$500 toward the financing of this conference.

### Report of Future Planning Committee

Dr. Meiling presented a report on the meeting of the Future Planning Committee held on January 20. The Council approved the report, which in essence terminated negotiations with Mr. J. Edwin Farmer with regard to a condominium proposal in the Market-Mohawk area.

The Council empowered the committee to explore the feasibility of obtaining new quarters on one of the following bases:

1. A building owned and operated by the Ohio State Medical Association.

2. A condominium venture in which the Ohio State Medical Association is the principal agent or one of several.

3. A long term lease in a suitable building.

### Huron County Amendments

The Council approved amendments to the constitution and bylaws of the Huron County Medical Society, which raises dues for active membership from \$15 to \$40, and adds a \$10 contribution to the American Medical Education Research Foundation for both active and associate members.

### Licking County Amendments

Amendments to the Constitution and Bylaws of the Licking County Medical Society, as redrafted by the OSMA legal counsel, were approved, contingent upon adoption by the society and submission of the revision thereof for formal approval by The Council.

### County Society Officers Conference

Mr. Edgar reported on the program for the County Society Officers Conference to be held on February 28.

### Statement on Increase in OSMA Dues

The Council approved a statement with regard to the factors making an OSMA dues increase necessary and asked that it be printed in *The Ohio State Medical Journal* and forwarded to county medical



society officers and delegates and alternates to the Ohio State Medical Association.

(See Statement beginning on Page 284.)

#### **St. Anthony Emergency Room Physicians Service, Inc.**

With regard to an announcement by Dr. Fulton regarding a corporation of physicians to operate the emergency room at St. Anthony Hospital, Columbus, it was decided to await the decision by the Columbus Academy of Medicine concerning this action, and authorize the president to thereupon refer this matter to the appropriate OSMA committee for study.

#### **Legislation on Statute of Limitations**

The Council reaffirmed its opposition to legislation which would extend the statute of limitations on malpractice actions from one to two years.

#### **Official Appointments of Executive Secretary And Assistant Executive Secretary**

The Council then went into executive session. Mr. Hart F. Page was officially appointed Executive Secretary of the Association and Mr. Charles W. Edgar was officially appointed Director of Public Relations and Assistant Executive Secretary. Mr. Page was also appointed Managing Editor and Business Manager of *The Ohio State Medical Journal*.

#### **Committee Reports**

**Hospital Relations** — The report of the Committee on Hospital Relations, based on a meeting held on January 17, was approved as presented. Such report made specific recommendations concerning hospital billing of physician services and called for a joint meeting of the Professional Relations Committee of the Ohio Hospital Association and the Committee on Hospital Relations of the Ohio State Medical Association to discuss and try to resolve this problem.

The report asked that the Ohio State Medical Association take the necessary action to prevent licensure of blood insurance programs in Ohio. The Council asked that the Director of the Ohio Department of Insurance be informed of this policy.

Consideration of a recommendation that Council endorse a "Guide for Release of Information from Medical Records" developed by the Cleveland Hospital Council was held over for a future meeting, with the request that members of The Council receive copies of such guide and that it be reviewed by the Association's legal counsel.

The Council approved the committee's recommendation that physicians take a more active part in areawide planning of health facilities, including a proposal for co-sponsorship with the Ohio Hospital Association of a meeting on areawide planning and on emergency room operation to be held early in the Fall of 1965. In addition, The Council asked for a report from the committee with regard to additional

plans for implementing physician participation in areawide planning activities.

A revision of the pamphlet entitled "Physician-Hospital Relations" by a joint subcommittee of the Ohio State Medical Association and the Ohio Hospital Association was approved.

**Mental Health** — A report on the January 17 meeting of the Committee on Mental Health was approved. Also approved was a proposal from the Comprehensive Mental Health Planning Project that the Ohio State Medical Association sponsor a meeting of 12 to 15 physicians from the area of general practice and the major specialties. This meeting will be of the workshop type and the physicians participating will be reimbursed for their expenses by Comprehensive Mental Health Planning. A report of the meeting will be submitted to the executive committee of Comprehensive Health Planning.

**Laboratory Medicine** — A report of the Committee on Laboratory Medicine on a meeting held on January 27 was approved, including the committee's recommendation that the Ohio State Medical Association approve in principle a proposed bill with regard to the licensure of clinical laboratories by the Ohio Department of Health and certification of clinical laboratory directors by the Ohio State Medical Board. Approval of this legislation was contingent upon the provision of a "grandfather clause" for physicians and others.

Another recommendation in the report was that the OSMA seek official objection from the Ohio Hospital Association with regard to the licensing in Ohio of Blood Service Plan Insurance Company of Scottsdale, Arizona.

**Cancer Coordinating Committee** — The report of the Ohio Cancer Coordinating Committee, dated October 11, 1964, was approved. It was specified that a brochure on "Five-Point Cancer Detection Program," contained in the report, be for distribution to physicians and through physicians only.

A bill to amend Section 3701.261 of the Revised Code relative to cancer registries was approved for sponsorship by the Ohio State Medical Association. This proposal makes it legal to report data to cancer registries which are "maintained and operated by a hospital registered under Section 3701.07 of the Revised Code, a county medical society chartered by the Ohio State Medical Association, or a board of health of a city or general health district."

**Disaster Medical Care** — A report on a meeting of the Committee on Disaster Medical Care held on January 10, 1965, was approved as presented.

The Council adjourned, setting a tentative date for the next meeting for March 7 and authorizing the president to call an earlier session if events indicate the need for one.

ATTEST: HART F. PAGE,  
Executive Secretary

# Increase in State Association Dues Recommended by The Council

THE COUNCIL of the Ohio State Medical Association at a recent meeting by unanimous vote adopted a resolution recommending to the House of Delegates that the annual dues of the Association be increased by \$15.00, making the dues \$50.00, effective January 1, 1966. This resolution will be presented to the House of Delegates at the 1965 Annual Meeting of the Association in Columbus, May 9-14. To better inform the membership of the necessity for this increase in dues, The Council issued a statement, outlining the various factors involved. Copies of this statement will be sent to secretaries of County Medical Societies with the request that the various factors be discussed at Society meetings; also, copies will be sent to delegates who will represent County Societies at the Annual Meeting in May.

## PERTINENT FACTORS REGARDING THE NECESSITY FOR A DUES INCREASE— A STATEMENT BY THE COUNCIL

"Many significant factors were seriously considered by The Council in weighing the decision to recommend unanimously to the House of Delegates that the Ohio State Medical Association dues be increased by \$15 a year.

"These important factors include the following:

"Factor No. 1: Until recent years, the Association paid only the expenses of our OSMA delegates to the American Medical Association's Annual Convention and Clinical Convention. Increased participation and more intensified activities by OSMA delegates in the AMA House of Delegates, plus an increase in the business of that House, resulted in the decision to pay the expenses of OSMA alternate delegates, so that they all could attend and participate in these activities, thereby helping to carry out the Ohio delegation's responsibilities in representing the physicians of Ohio. The alternates previously paid their own expenses to these meetings.

### ANNUAL MEETING

"Factor No. 2: Costs of the Ohio State Medical Association Annual Meeting have increased while, at the same time, the number of commercial exhibits, which pay for a major portion of Annual Meeting expenses, have decreased. In recent years, the Annual Meeting was extended one day to enable members of our House of Delegates to participate more fully in the scientific portions of the meeting. It also enabled a more comprehensive scheduling of the scientific programs.

"Another important and very worthwhile cost increase for the meeting is the granting of cash awards, started in 1964, for outstanding scientific and educational exhibitors in deserved recognition for the

major contribution they make toward the success of the meeting.

"Our OSMA Annual Meeting is recognized as one of the nation's finest and largest postgraduate medical assemblies and should receive continued support.

"Factor No. 3: In keeping with the widely increased interest and activities in helping outstanding young men and women to become doctors of medicine, a second \$2,000 Rural Medical Scholarship was added in 1964. The original \$2,000 scholarship was initiated in 1948. These scholarships bring recognition to the physicians of Ohio for their concrete expression of interest in this important field. Each scholarship consists of \$500 a year for four years of medical school.

### INCREASED ACTIVITIES

"Factor No. 4: There have been increases in Council and Committee activities, as well as some additional committees established. Matters both within and outside of medicine affecting medicine and health have made it necessary to hold more Council and committee meetings. Of equal importance is the fact that District Councilors are working more closely with the County Medical Societies, their officers and delegates to the OSMA.

"OSMA committees have increased the number of programs and projects. Every new program or project has been established to meet a recognized need, or situation, that has arisen, and the OSMA has acted and will continue to act to meet these new conditions as they arise.

"Factor No. 5: Continued expansion of pressures and demands by those forces seeking government medicine have forced us to expand our counter-programs to meet this constantly increasing threat of government domination of our profession.

"Unlike the advocates of government medicine



who promise magic, there is no magic whereby our continuous fight to preserve our system of medical care can be carried on without expenditures.

"We are proud to say that the OSMA campaign has been effective. It has required funds for campaign materials, communication with members and with other interests friendly to us, and communication with the public.

"Our public education program last fall produced excellent results. Now, we must continue our efforts to tell the people of Ohio the real facts about health care of the aged. We must continue to acquaint them, and also some of our own members, with medicine's positive program.

#### OHIO STATE MEDICAL JOURNAL

"Factor No. 6: *The Ohio State Medical Journal* has suffered a considerable loss in advertising revenues in recent years. Advertising volume has been considerably below that of the previous 10 years.

"Our *Journal* is not alone in this situation. Almost all state association journals are experiencing the same problems. This situation is due entirely to a considerable reduction in state journal advertising on the part of the pharmaceutical industry and related industries.

"Nevertheless, we have been able to maintain without curtailment the excellent scientific section of *The Journal* under the very capable editorship of Dr. Perry Ayres. This has been done by appropriating a substantial portion of dues revenues to meet the difference between Journal advertising revenues and production costs; also, by reducing the news and organization section of *The Journal*. Another cost reduction was achieved by obtaining a conditional reduction in the printing contract. All of these have helped to reduce the gap between advertising revenues and publication costs.

"Factor No. 7: In the field of postal rates, association supplies, literature and materials, considerable cost increases have been experienced.

"There have been increases in all classes of postal rates in the past two years. At this writing, the Post Office Department had announced that it would seek additional increases in postal rates. Also, the mail volume of the Association has increased significantly.

"Every physician practicing medicine today knows that costs of his supplies and materials have increased. OSMA Headquarters has not escaped this inflation.

"Another development is the decision of the AMA two years ago to sell pamphlets and booklets that previously were made available without cost. Further, the AMA discontinued discounts for quantity orders of materials which happen to be an important part of some of our programs. These pamphlets, booklets, literature, etc., are a vital part of the Association's role in making this important information available to members, to county medical societies, to

#### This Resolution Will Be Presented To the House of Delegates

The Association's Auditing and Appropriations Committee at a recent meeting presented the following resolution which was adopted by The Council without a dissenting vote:

WHEREAS, At the 1965 Annual Meeting of the Ohio State Medical Association the delegates will act on a resolution to waive dues for members over 70 years of age on their request and such an amendment, if presented, will result in a marked decrease in revenue to the Association; and

WHEREAS, The Association is faced with the situation in which expenses are rising but income is not increasing, making it necessary to include income from previous years to bring the 1965 budget into balance; and

WHEREAS, Ohio is currently one of three state medical associations with the lowest dues in the country; and

WHEREAS, Medicine faces its time of greatest challenge, and has found it necessary to expand existing programs as well as to initiate additional activities;

THEREFORE, BE IT RESOLVED, That The Council of the Ohio State Medical Association sponsor at the May 1965 Annual Meeting in the House of Delegates a resolution to increase the annual Ohio State Medical Association dues to \$50.00, effective January 1, 1966.

schools and colleges, to voluntary health organizations and to the public in general.

"Factor No. 8: It is anticipated that there will be an increase in headquarters office rental in 1966. Also, it has been necessary in the past three years to acquire a moderate amount of additional office space.

"Factor No. 9: This 1965 House of Delegates will consider a proposed amendment to the Constitution and By-Laws which would exempt from dues all members age 70 or older. This amendment, if enacted, will reduce current revenues considerably, perhaps as much as \$12,000. Also, additional funds will be required to continue certain membership benefits for this dues-exempt group.

"Factor No. 10: Despite considerable increases in operating costs, there have not been parallel increases in Association revenues. With the exception of *Journal* revenues (and the *Journal* must be partially subsidized) and Annual Meeting exhibit revenues (which do not cover the cost of the meeting), the Association must depend entirely on dues to finance its operations.

"Factor No. 11: Your Council is proud to report that the annual County Medical Society Officers

Conference and the annual Special Programs for Medical Students continue to grow. While this growth means additional expenditures, it is certainly hoped that such growth will continue.

#### IN CONCLUSION

"At the present rate of \$35 a year, your OSMA is tied with two other states in having the lowest dues.

"At the \$50 a year rate strongly recommended by your Council, an OSMA member would be paying less than 14 cents a day for his membership. The OSMA member receives a very considerable variety of services for his dues.

"In these times when so many factors both inside and outside medicine directly involve medicine, it is vitally important that this Association's services and activities be continued on a strong basis. This is a situation that is not of our making, but it is very real and we must face it.

"The Council is pleased to report that, despite this era of soaring costs, these programs can be continued at a cost of less than 14 cents a day for each member.

"Your Council, therefore, unanimously urges your most serious consideration of a favorable action on the recommended dues increase."

### OSU Studies Proposed Overseas Research-Training Center

Ohio State University has begun a study aimed at determining the feasibility of establishing an International Center for Medical Research and Training at an African university.

The study is being financed by a \$12,000 grant from the U.S. Public Health Service, which also would underwrite cost of the center should one be organized.

Dr. George W. Wharton, professor and chairman of Ohio State's department of zoology and entomology and one of the investigators in the study, said the ICMRT would provide Ohio State students and faculty an opportunity to conduct cooperative studies in Africa with colleagues from the African university.

Dr. Carl E. Venard, professor of zoology and entomology, was scheduled to begin a six-week trip to Africa to determine possible arrangements which may be made.

Later, Dr. John C. Weaver, vice-president for instruction and dean of faculties, Dr. Richard L. Meiling, dean of the College of Medicine, and Dr. Wharton will visit the area to make final arrangements. Dr. Weaver is principal investigator of the project.

Dr. Wharton said the Ohio State center, which would be the first established by the United States in tropical Africa for this type of training, could be in operation within a year and one half.

## Do You Know? . . .

Again national honors have come to Dr. Herbert M. Platter, venerable secretary of the State Medical Board of Ohio. An annual event in the program of the Federation of State Medical Boards of the United States had been named in his honor, the "Herbert M. Platter" luncheon.

\* \* \*

Thomas H. Mallory, of Hillsboro, winner of the Ohio State Medical Association's Rural Medical Scholarship at the beginning of his freshman year in medical school, has been named president of the senior class at Ohio State University College of Medicine. Two scholarships are now awarded annually, each helping a student through his four years of medical school.

\* \* \*

Dr. George Crile, Jr., Department of Surgery, Cleveland Clinic, was guest speaker for the February 9 meeting of the Fort Steuben Academy of Medicine, where he spoke on "Current Thyroid Therapy." The dinner meeting was held in the Fort Steuben Hotel, Steubenville.

\* \* \*

Dr. Arnold M. Weissler, associate professor of medicine in the Ohio State University College of Medicine, has received a renewal grant of \$12,672 from the U.S. Public Health Service. The funds will support his research in ventricular ejection studied by simplified techniques.

\* \* \*

In a recent announcement about the American College of Surgeons sectional meeting in Philadelphia, the name of Dr. Wesley Furste, Columbus, was inadvertently omitted among Ohioans participating. He was moderator of a panel discussion on trauma at that meeting. Among his activities in the near future, Dr. Furste will present a paper entitled "Prophylaxis Against Gas Gangrene and Tetanus for the Wounded Patient," at the School of Medicine of the University of Pennsylvania, Philadelphia, May 8, and will be moderator of a discussion on "The Diagnosis and Management of the Patient with Multiple Injuries" at the same session.

\* \* \*

Dr. Sidney Nelson, professor and chairman of the Department of Radiology, Ohio State University, will deliver the 17th annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati on April 24 and 25.

\* \* \*

Dr. Benjamin Pasamanick, professor of psychiatry in the Ohio State University College of Medicine, served as chairman for the opening day session of the American Psychopathological Association meeting in New York City.





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Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

**SEARLE**

*Research in the Service of Medicine*

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*

— Justice Robert H. Jackson in AAA Supreme Court Case, 1942

## FAIR PLAY IS ASKED FOR THE DRUG INDUSTRY

In the present crisis of government encroachment into every phase of professional, business, and industrial life, it is not surprising to find one branch of the business world offering to stand by another.

In its December newsletter, the Empire Trust Company of New York deplors harassment "from within and without" of the U. S. pharmaceutical industry, which it calls "the business of living."

"Accused of cynical opportunism, embroiled in legislative and judicial controversy," the letter states, "the U. S. pharmaceutical industry has become the subject of attack and rebuttal, claim and counterclaim to an extent unparalleled in the recent history of any American industry."

Unlike such industries as aircraft and missiles, or electrical equipment and communications, where research for the most part is financed by the government, pharmaceutical research is underwritten almost entirely by the industry.

The newsletter further points out that even such processes as the coating of pills may take years to develop and represent millions of dollars of investment.

A gross injustice to the American pharmaceutical industry was revealed recently when it was reported that the Department of Defense was buying large quantities of drugs from a European manufacturer who had "pirated" its formula from an American drug company. "The situation is not only insidious; it is appalling," the newsletter states.

Many other injustices are pointed out in the newsletter; for example, the move to abolish drug and pharmaceutical trade names.

Admittedly, the pharmaceutical industry "too must have its regulatory standards and procedures," the newsletter states. "But these matters must be assessed and determined with rationality, with perspective, and not with emotionalism or with rancor. And the U. S. pharmaceutical industry cannot solve these problems without the objective understanding of the American public," the letter further states, and concludes with these words:

"Think about it. And then, as partners, let's do

our intelligent and thoughtful share to keep this vital industry as healthy and dynamic as the pharmaceutical industry has helped us to become—in our businesses, our professions, and our daily lives."

## 14 MILLION EXPOSURES ON ELDERCARE NEED INTENSIVE FOLLOW-UP

The medical profession's story about the Eldercare Act of 1965 now before Congress is scheduled to be told 14 million times in Ohio. An advertisement directed to the public is appearing in every daily and every weekly newspaper in Ohio for three consecutive weeks. The combined circulation of these newspapers, multiplied by three, adds up to 14 million times this ad will appear in print.

These advertisements are only the seed in a much broader campaign. Like the detail man who follows up the advertisement for his product with a personal call, these advertisements must be followed by a vigorous campaign in every County.

At the called meeting of County Medical Society Officers, held February 13 in Columbus to discuss this subject, a spontaneous resolution was passed by acclamation "pledging all efforts necessary to obtain passage of H. R. 3727" (the Eldercare Act of 1965).

Officers of the State Association stress that this is what is needed. In every county there must be personal contacts, talks before local groups, conferences with newspaper editors, radio and TV personnel, talks with persons in governmental positions, and vigorous contacts with Congressmen.

Paul Donelan, legislative attorney in the AMA Washington Office, spoke before the County Medical Society Officers Conference, and brought to Ohio definite rays of light in an otherwise gloomy picture. There is hope that Congress will consider favorably the Eldercare program and stall definite action on the administration-backed Medicare scheme, he told his audience.

Congressmen are most influenced by clear, concise letters written by constituents of their own districts "who know what they are talking about," Mr. Donelan told his audience.



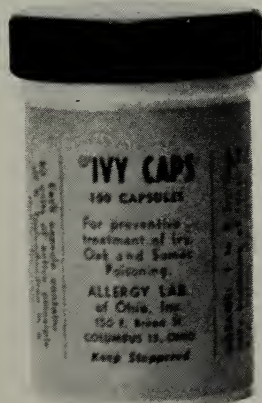
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# Ad Astra

**Chester Badertscher, M. D.**, Cleveland; Western Reserve University School of Medicine, 1931; aged 59; died January 17; member of the Ohio State Medical Association. A physician for a number of years, Dr. Badertscher was medical director of the Bedford plant of Lear-Siegler, Inc., for about 10 years. Survivors include his widow, two sons, a daughter, a brother and a sister.

**Howard E. Boucher, M. D.**, Columbus; Ohio State University College of Medicine, 1910; aged 80; died January 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Boucher was living in retirement after a long career as physician and surgeon in Columbus. A veteran of World War I, with a rank of colonel in the Army, Dr. Boucher was a member of the Association of Military Surgeons. Other affiliations included membership in several Masonic bodies, the Presbyterian Church, the Lions Club and the Last Man's Club. Survivors included his widow, a son, a daughter and a sister.

**John T. Boxwell, M. D.**, Marion; University of Michigan Medical School, 1930; aged 61; died March 29, 1964; member of the Ohio State Medical Association and the American Medical Association. Dr. Boxwell began his practice in Prospect and later maintained an office both in Prospect and in Marion. In 1963 he became surveyor for the Joint Commission on Accreditation of Hospitals. He was serving in this capacity at the time of death in Waco, Texas. Dr. Boxwell was a member of the Presbyterian Church and several Masonic orders. His widow survives. (Editor's Note: The staff regrets this delay in publishing Dr. Boxwell's obituary.)

**Robie Thomas Childers, Jr., M. D.**, Richmond, Indiana; Emory University School of Medicine, 1951; aged 40; died January 22; former member of the Ohio State Medical Association. Dr. Childers was formerly on the staff of the Massillon State Hospital. Recently he was associated with the Richmond State Hospital in Indiana. Survivors include his widow, three daughters, two sons, his parents and a grandmother; also three sisters.

**Ernest Lee Crum, M. D.**, Lodi; Starling Medical College, Columbus, 1905; aged 85; died January 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Crum began his practice in Lodi immediately after completing his medical training in Columbus, and practiced for some 60 years there. Among professional activities, he was county coroner for a number of years, was also

physician for the B & O Railroad, and for other groups. A member of the Methodist Church and several Masonic bodies, he is survived by a daughter and a brother.

**Martin Mayer Horowitz, M. D.**, Galion; Ohio State University College of Medicine, 1940; aged 50; died January 6; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician and surgeon in Galion for about 24 years, Dr. Horowitz was a trustee of the Galion Community Hospital. He was the first president of the North Central Ohio Chapter of the American Academy of General Practice. Affiliations included membership in the Kiwanis Club, the B'nai Jacob Congregation, and several concert music groups. A veteran of the Army Air Force Medical Corps during World War I, he is survived by his widow, two sons, a daughter, his mother and a sister.

**Roy C. Hunter, M. D.**, Wapakoneta; Eclectic Medical College, Cincinnati, 1902; aged 88; died January 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Hunter began his practice in Wapakoneta in 1902, shortly after completing his medical training period. He continued there in practice until his retirement in 1953, and for many years was also Auglaize County health commissioner. Dr. Hunter was a veteran of both the Spanish-American War and World War I. Affiliations included membership in the Lutheran Church and several Masonic bodies. Surviving are his son, Dr. Forrest Hunter, of Lima, and a sister.

**Almus Calvin Lawrence, M. D.**, Crooksville; Eclectic Medical College, Cincinnati, 1924; aged 69; died January 12; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Lawrence devoted his entire medical career to practice in the Muskingum County area, beginning at Roseville, but moving shortly thereafter to Crooksville. He served on the local board of education and was a member of the Christian Church, several Masonic bodies and the Knights of Pythias Lodge. Among survivors are his widow and two brothers.

**Virgil Egbert McEldowney, M. D.**, Newell, West Virginia, and East Liverpool; aged 67; died January 17; member of the Ohio State Medical Association and the American Medical Association. Dr. McEldowney practiced for many years in the East Liverpool vicinity, making his residence on the West



Virginia side of the river. A veteran of World War I, Dr. McEldowney was a member of the Presbyterian Church, the Masonic Lodge and the local Chamber of Commerce. He is survived by his widow, two daughters, a son and two brothers.

**Richard LeRoy McFarland, M.D.,** Columbus; Ohio State University College of Medicine, 1935; aged 55; died January 14; member of the Ohio State Medical Association, the American Medical Association, the American Fracture Association and the Industrial Medical Association. A practicing physician and surgeon in Columbus for many years, Dr. McFarland was one of the founders of the Lincoln Memorial Hospital and was president of its board at the time of death. Among affiliations, he was a member of the Masonic Lodge and the Kiwanis Club. Survivors include his widow, a daughter, two sons, his mother, two brothers and two sisters.

**Clifford Shelby Palmer, M.D.,** Lisbon; Eclectic Medical College, Cincinnati, 1917; aged 78; died January 19; member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in the Lisbon and Massillon areas, Dr. Palmer was a former health commissioner for Massillon and for Columbiana County. Among affiliations, he was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow and four sons.

**Noah J. Rentz, M.D.,** Fort Myers, Fla. (formerly of Cleveland); Medical College of South Carolina, 1927; aged 60; died January 7; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician in the Cleveland area for about 30 years, Dr. Rentz retired in 1959 and moved to Florida. He was a member of several Masonic bodies and the Kiwanis Club. Among survivors are his widow, a daughter, three brothers and two sisters.

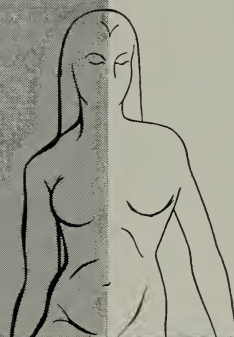
**Moses A. Richardson, M.D.,** Akron; Meharry Medical College, 1921; aged 72; died January 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Richardson practiced for about 20 years in Akron before illness forced his retirement. A native of Tennessee, he formerly practiced in Missouri. In addition to his professional associations, he was a member of the Baptist Church and the Prince Hall Affiliation of Masons. His widow and a brother survive.

**Edward Carl Roy, M.D.,** San Antonio, Texas (formerly of Parma and Cleveland); St. Louis University School of Medicine, 1933; aged 57; died January 21; former member of the Ohio State Medical Association; member of the American Medical Association and the American Academy of General Practice. Dr. Roy practiced for about 27 years in the Cleveland area before he moved out of the state in

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1961. He is survived by his widow, a daughter and a brother.

**Stanley Charles Schiller, M.D.,** Mansfield; Ohio State University College of Medicine, 1916; aged 74; died January 23; member of the Ohio State Medical Association and the American Medical Association; past-president of the Richland County Medical Society. A physician in Mansfield for many years, Dr. Schiller was associated in practice with his son-in-law, Dr. Albert H. Voegelé. He was a member of the Catholic Church and several Catholic orders. Among survivors are his widow, two daughters and a son.

**Eleanora Louise Schmidt, M.D.,** Phoenix, Arizona (formerly of Athens); Washington University School of Medicine, 1927; aged 70; died January 10; member of the Ohio State Medical Association and the American Medical Association. A former practicing physician in the Athens area, Dr. Schmidt moved out of the state in 1961.

**Albert G. Schraff, M.D.,** Rocky River; Western Reserve University School of Medicine, 1950; aged 43; died January 3; member of the Ohio State Medical Association and the American Medical Association. A lifelong resident of the Cleveland area, Dr. Schraff practiced for a time in association with his father, the late Dr. Raymond J. Schraff. Dr. Albert Schraff was an ear, nose and throat specialist. He was a veteran of World War II, during which he served in the Medical Corps of the Navy. Survivors include his widow, seven sons, and two daughters; also a brother and three sisters.

**Herman Karl Schueler, M.D.,** Toledo; medical degree from the Medical Faculty of Philipps University, Marburg, Prussia, 1949; aged 43; died January 20. Dr. Schueler had only recently moved to Toledo from an association with the Miners Memorial Hospital, Harlan, Ky. A native of Germany, he previously studied in the eastern states. Survivors include his widow, four children; also his mother, a brother and a sister in Germany.

**Troy Adam Spitler, M.D.,** Findlay; Ohio State University College of Medicine, 1913; aged 77; died January 15; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A native of Hancock County, Dr. Spitler practiced for more than 50 years in the Findlay area. He was a veteran of World War I. For many years, Dr. Spitler was a member of the city board of health. Other affiliations included membership in the American Legion, several Masonic bodies, the Elks Lodge, the Methodist Church and Sons of the American Revolution. Survivors include his widow, a son and two daughters.

**Clifford John Strachley, M.D.,** Skyland, N. C. (formerly of Cincinnati); University of Cincinnati College of Medicine, 1920; aged 68; died January 4;

member of the Ohio State Medical Association, the American Medical Association, American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. Strachley retired and moved to North Carolina about three years ago after a practice of long standing in Cincinnati where he specialized in cardiology. His practice was in association with his father, the late Dr. Irwin Strachley, Sr., and his brother, Dr. Irwin Strachley, Jr. A son, Dr. Clifford Strachley, Jr., also practices in Cincinnati. Other survivors are his widow and two daughters.

**Michael Varga-Sinka, M.D.,** Lorain; medical degree from the Faculty of Medicine of the University of Szeged, Hungary, 1942; aged 48; died January 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Varga-Sinka came to this country in 1950 and began practice in Lorain after taking several years of residency training. He was a member of St. Anthony Church in Lorain. Surviving are his widow, two sons and a daughter; also a brother and two sisters in Hungary.

**Charles F. Ward, M.D.,** Fairview Park (Cleveland); Stritch School of Medicine of Loyola University, 1934; aged 56; died January 1; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. A practicing surgeon in the Cleveland area for many years, Dr. Ward formerly practiced in association with his father, the late Dr. Charles E. Ward. Dr. Charles F. Ward was one of the first physicians of the area to volunteer after the Pearl Harbor attack and served in the Naval Medical Corps during World War II, attaining the rank of commander. He is survived by his widow, two daughters, a sister and a brother.

**Sigmund Wassermann, M.D.,** Cleveland; Faculty of Medicine of the University of Vienna, 1905; aged 87; died January 27. A native of Austria, Dr. Wassermann came to this country in 1908. He returned to Europe for further study and was held by local restrictions until the early 1930's. From that time until 1957 he practiced in the Cleveland area. His widow and a sister survive.

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### **Cleveland Clinic Foundation Offers Urology Course**

The Cleveland Clinic Education Foundation is offering a postgraduate course entitled "Advances in Urology" on Wednesday and Thursday, March 17 and 18. The course will be presented in the auditorium of the Education Building. A faculty consisting of members of the clinic staff and distinguished guest speakers will present the program.

Additional information may be obtained from the Cleveland Clinic Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.





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## M. D.'s in the News

Dr. Jack Schreiber, Canfield, member of the Speakers' Bureau of the American Medical Association, spoke before the Wesleyan Men of the First Methodist Church in Warren.

\* \* \*

Dr. Norman H. Baker, Columbus, discussed heart surgery, as guest speaker at the annual meeting of District 13 of the Ohio State Nurses Association in Lima.

\* \* \*

Dr. William C. Downing, Painesville, addressed a group of Division 27 of the Practical Nurses Association of Ohio, using as his topic, "Modern Changes in Medicine."

\* \* \*

Dr. Morris W. Selman and Dr. Wallace A. McAlpine, both of Toledo, discussed open heart surgery at a meeting of the Fostoria Woman's Club. Dr. Lowell K. Good, president of the Seneca County Heart Council, introduced the speakers.

\* \* \*

A grant of \$128,000 has been awarded by the National Cancer Institute of the U. S. Public Health Service, for cancer research at the Institute for the Study of Human Reproduction of St. Ann Hospital, Cleveland.

\* \* \*

Dr. Robin Anderson, of Cleveland, spoke at the annual dinner meeting of the Ashtabula County Nurses Association, using as his topic, "Plastic Surgery — Fact or Fantasy."

\* \* \*

Dr. George H. Dietz spoke before the Youngstown Kiwanis Club where he discussed proposed government eldercare programs.

\* \* \*

Dr. Lester Persky, Cleveland, spoke on the topic, "Diagnosis and Surgical Developments in Renal Disorders," at a meeting of the Kidney Foundation of Ohio.

\* \* \*

Dr. Edwin H. Artman addressed a meeting of the Chillicothe Life Underwriters Association, where he contrasted proposed governmental programs for Medicare with the Eldercare program of the AMA and other similar programs.

\* \* \*

Dr. James L. Smeltzer, Youngstown, discussed strokes at a meeting of the local Registered Nurses organization.

\* \* \*

Dr. Max Lesy, Cleveland, recently was elected president of Phi Lambda Medical Fraternity and the Medical Students' Aid Society.

## Group Therapy Helps Couples In UC Research Project

Psychiatrists at the University of Cincinnati Medical Center are finding that some ailing marriages can be helped by group psychotherapy for couples — an approach some experts have heretofore considered ineffective.

The researchers noted that some couples who reject individual psychotherapy may accept the couples' group, and when the marriage itself is the main trouble spot, obtain very meaningful help.

Chief investigators in the Cincinnati University study were Dr. Anthony Gottlieb, research fellow in the department of psychiatry, and Dr. E. Mansell Pattison, former research fellow, now at the National Institute of Mental Health in Washington, D. C.

The study was made at Central Psychiatric Clinic, one of the nation's largest out-patient mental health clinics. It is operated at Cincinnati General Hospital by the University of Cincinnati psychiatry department, with support from the Community Chest and the State of Ohio.

A report of Drs. Gottlieb's and Pattison's conclusions appeared in the January issue of *Frontiers of Clinical Psychiatry*.

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# Activities of County Societies...

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### BUTLER

An excellent attendance was recorded at the third annual Medical Seminar sponsored by the Butler County Society. The audience consisted of those from Butler County as well as physicians from surrounding counties.

The afternoon program on "Trauma in Children" was followed by dinner and an evening of entertainment.

### HAMILTON

Dr. Francis M. Foster, professor of neurology at the University of Wisconsin, was guest speaker at the January 19 meeting of the Academy of Medicine of Cincinnati, where he spoke, using the topic, "Recent Developments in the Nature and Management of Epilepsy."

For the February 16 meeting of the Academy, a panel discussion was held on the subject, "Differential Diagnosis of Abdominal Pain." On the panel were Dr. C. Rollins Hanlon, professor of surgery, St. Louis University School of Medicine; Dr. Joseph Kirsner, professor of medicine at the University of Chicago; and Dr. Harry Mellins, professor of radiology, Down State Medical Center, Brooklyn, N. Y.

## Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

### DARKE

The Darke County Medical Society met at Wayne Hospital Company in Greenville on January 19 for dinner and a business meeting. The program centered around a motion picture showing "Highlights of the AMA Convention in San Francisco."

### MONTGOMERY

Installation of the Montgomery County Medical Society's officers for 1965 took place at the Society's

annual inaugural meeting on January 15 at the Biltmore Hotel in Dayton.

Entertainment for the evening was provided by the Montgomery County Medical Society Glee Club under direction of Dr. W. J. Lewis.

Dr. Mason S. Jones was installed as the Society's 116th president. Taking office as president-elect was Dr. Charles E. O'Brien; as vice-president, Dr. Lewis O. Frederick; as secretary, Dr. Junius E. Cromartie; as treasurer, Dr. James F. Leary and as trustee, Dr. Joseph M. Wilson.

Two veteran Dayton physicians were honored at the meeting and given 50-Year Awards for their outstanding contributions as physicians over a period of a half century. They are Dr. Frank S. Shively, Sr., and Dr. James C. Walker. The *Journal Herald* of Dayton published a feature article relating primarily to the work of these two doctors of the community.

### PREBLE

Dr. W. C. Clark, Jr., of Eaton, was re-elected president of the Preble County Medical Society for a third term, at the January dinner meeting of the group. Dr. J. D. Darrow, also of Eaton, was elected secretary-treasurer. The group agreed to sponsor an informative display at the 1965 Preble County Fair.

## Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

### ALLEN

There were 88 members and guests present on January 19 at the Shawnee Country Club for the meeting of the Lima and Allen County Academy of Medicine. The speaker of the evening was Dr. Harold F. Falls, professor of ophthalmology at the University of Michigan Medical School. Dr. Fall gave a most stimulating and beautifully illustrated discus-

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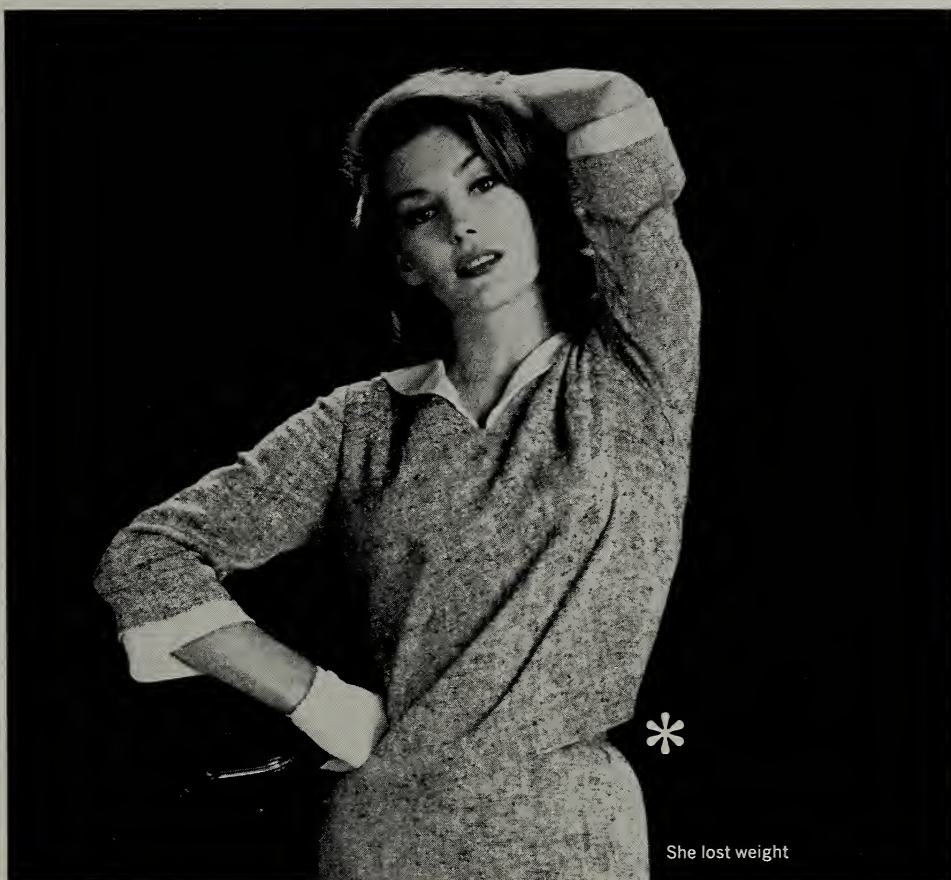
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trust fund is being turned over to the health department to buy more polio vaccine. Surplus funds from the Sabin Oral Sundays program, held in 1962 and 1963, are being held in trust to support community disease-prevention programs.

New members welcomed at Tuesday's meeting were Jacques VerMeeren and new health commissioner, Dr. William Boswell. —*Sandusky Register*.

#### LORAIN

Fifty members and eight guests attended the regular meeting of Lorain County Medical Society on February 9 at Oberlin Inn. The meeting was preceded by a social hour and dinner.

Attention was drawn to OSMA's presentation of Charles L. Hudson, M. D., Cleveland, as candidate for president-elect of the American Medical Association.

Richard Carl Zbornik, M. D., was elected unanimously to Associate membership in the Society, and Hector P. Siat, M. D., to Active membership.

Report was read of the meeting on January 19 between the County Commissioners and members of Council of Lorain County Medical Society, together with the Utilization Committee of the Society on Pleasant View T. B. Sanatorium. The report concerned the various aspects being considered in rela-

tion to the Society's proposed recommendation that the Institution be maintained as a medical facility if at all possible.

Dr. Cicerella, member of the Society's newly formed committee on Nursing Education in Lorain County, reported on a meeting on January 27 with the president of Lorain County Community College, pertinent to their proposed "Associate Degree" program in nursing, and the overall effect of such a program.

L. C. Meredith, M. D., Eleventh District Councilor, emphasized the need for membership action in the "stepped-up" campaign for the Doctors' Elder-care Program. The special meeting called by Robert E. Tschantz in Columbus on February 13 was attended by officers of the Society.

John Wherry, M. D., president, drew attention to the interesting program planned for the March meeting, when the Woman's Auxiliary will be invited. He then introduced William L. Boykin, Executive Director of Lorain County Rehabilitation Center, who had arranged the program of the evening. This was in the form of a Panel Discussion with staff of the Rehabilitation Center as participants; they included a Physiatrist, Psychologist, Physical Therapist, Occupational Therapist, Speech and Hearing Ther-

when abnormal capillary permeability and fragility are factors in

**bleeding**

in such conditions as:

**habitual abortion**

**threatened abortion**

**purpura** (nonthrombocytopenic)

**gingivitis**

duo



apist, and a Pre-School Teacher. They illustrated the team approach to rehabilitation as they work towards the goal of enabling the handicapped to adapt to working and functioning within their limitations.

#### WAYNE

Ohio's Aid for the Aged health care program is superior to the proposed federal "Medicare" program, the state's Aid for Aged Division chief told area physicians Wednesday night (Jan. 13).

Speaker at a Wayne County Medical Society dinner at Stark's Restaurant was division chief Clarence V. Tittle, Jr. He told some 30 Wayne County doctors plus guests from Holmes County that persons in Ohio over 65 have more than adequate services available to them without the federal program.

The meeting was the first conducted by new Society officers, Drs. John M. Robinson, president; Howard C. MacMillan, vice-president; and Richard Watkins, secretary-treasurer, all of Wooster.

Ohio Medical Society delegates are Dr. Burney Huff of Wooster and Dr. Robert Reiheld of Orrville.

Among guests were five Apple Creek State Hospital physicians from Cuba.—*The Daily Record*, Wooster.

#### Seminar on Premature Care Scheduled in Cincinnati

The Good Samaritan Hospital, Cincinnati, announces the Third Annual Seminar on Premature Care to be held on April 15 from 1:00 p. m. to 6:00 p. m. Guest speakers will include:

Gerard B. Odell, M. D., associate professor of pediatrics, The Johns Hopkins Hospital, Baltimore,

Virginia Apgar, M. D., director, Division of Congenital Malformations, The National Foundation, New York.

Henry C. Cramblett, M. D., professor of pediatrics, Ohio State University, Columbus.

There are no registration fees but physicians planning to attend are requested to contact James J. Englert, M. D., Chairman, Premature Seminar, Good Samaritan Hospital, Cincinnati, Ohio, for reservations.

The 1965 Scientific Session of the American Cancer Society will be held at the Drake Hotel in Philadelphia, Pa., June 16. This symposium on "Hormones and Chemotherapy for Cancer—a Critical Appraisal" is open to all members of the medical and dental professions, and students. Details may be obtained from the American Cancer Society, 219 East 42nd St., New York, or from local cancer societies.

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# Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Publicity Committee  
Chairman, 2442 Dorman Dr., Portsmouth

LAST MONTH a physician's widow died. She was a charter member of my county auxiliary (Scioto, October 1940) and she merits this special mention because she was a very special person. Mrs. T. C. Crawford was well over eighty-five years young, and she could only celebrate her birthday every four years because she had been born on a February 29.

That perhaps in itself made her rather special, but that obviously is not the reason for this tribute to her. Rather it is because of what she stood for — a woman fiercely devoted to the interest of the medical profession who, until just a few years ago, was one of the most dedicated members of our group. For many years she was the "Story Lady" to a class of crippled children, one of the auxiliary's pet projects. Even when she was well along in her seventies, Mrs. Crawford never failed those children on her appointed days. She loved those handicapped youngsters, she worried over them, she planned special parties for them, she saw to it that the auxiliary came through with clothes, special food, entertainment, toys and whatever else was needed for their comfort.

Stella Crawford had been a widow for many, many years. But she considered herself an integral part of the medical family and she refused to sit in the proverbial rocking chair and do nothing but rock. No one could more convincingly argue the fallacies of socialized medicine than she; no one was a more active supporter of AMA-ERF, Health Careers, Health Education. She was a member of a number of civic organizations and she never failed to espouse medicine's cause. She loved everybody, and everybody loved her.

"A doctor's widow has no less a responsibility toward her husband's profession than she had as that doctor's wife," she always declared. It is well worth noting.

## Newspaper Clippings Reveal . . .

That the Clermont County Auxiliary presented a record play and records to the School for Retarded

Children recently. Funds for the gifts were raised at a benefit dinner at the home of Mrs. Charles M. Simmons, president-elect. Mrs. Agnella DeFelice is director of the retarded children's program; Mrs. A. Gordon Schulze is community service chairman; and Mrs. Albert W. Van Sickle is auxiliary president.

1965 is off to a good start in Cuyahoga County. Two "Living Room" Learning Courses have been received with considerable enthusiasm. The money management course is taught by Mrs. W. H. McGraw, a doctor's wife, and has enrolled thirty members. The Short Story Course started in January and has 18 enthusiastic participants. Cuyahoga's February 24 meeting repeated last year's successful attendance at a rehearsal of the Cleveland Symphony Orchestra.

The group is continuing its work with the Poison Information Center. Volunteers under the chairmanship of Mrs. W. James Gardner, took a short training course on follow-up calls. These women have been given a list of individuals who had previously called the center for help. The essential purpose is to ascertain to what extent such persons were helped and to maintain a record of the results for the Academy.

## A Unique Idea

Franklin County Auxiliary has been doing something for several years that should be of interest to auxiliaries all over the state. The group "adopted" a ward at the Columbus State Hospital and since then has sustained a regular program for that ward every two months. The doctors' wives take cookies and coffee to the ward and play games with the patients. In addition, there are special parties. In October, the women promoted a bingo party complete with prizes and refreshments. In December, the patients were treated to a Christmas Party with all the trimmings. There will be two other such festive occasions — one in February and one in April. Such a project has tremendous possibilities. It's something to be "copied" — to everyone's advantage!

The Franklin County group is now in its fourth season of another outstanding service. This time it is the Tuberculosis Association with whom the

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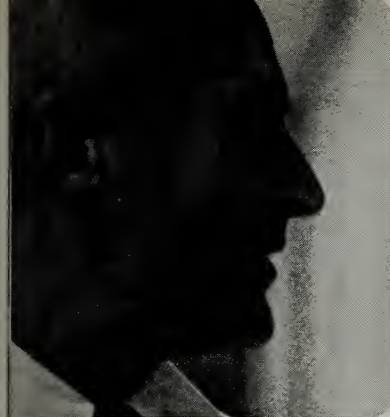
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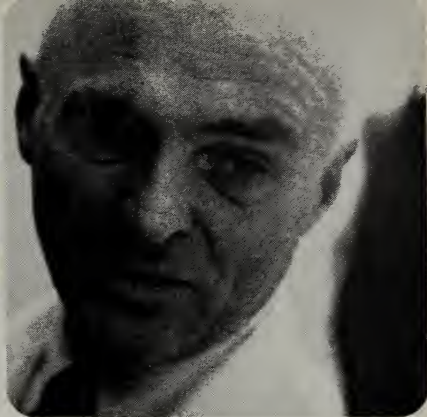




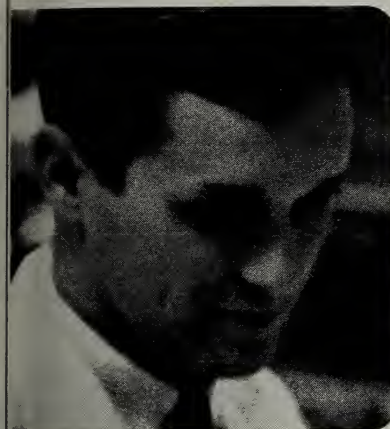
...you a cup of coffee?



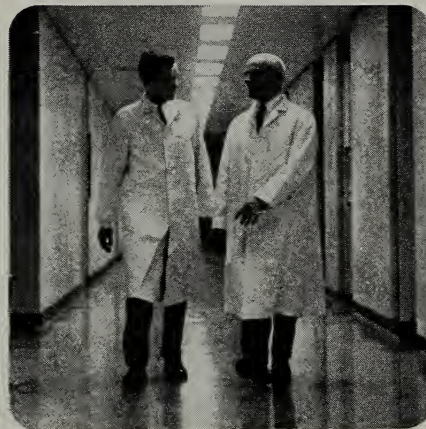
Fine! This last patient...



Mrs. Jones?



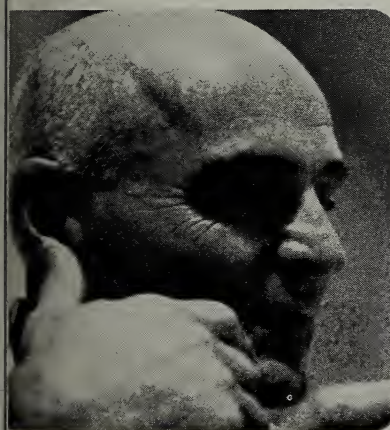
...es, sir. She's down to 140/85.



Right. When we started, she was 195/120.



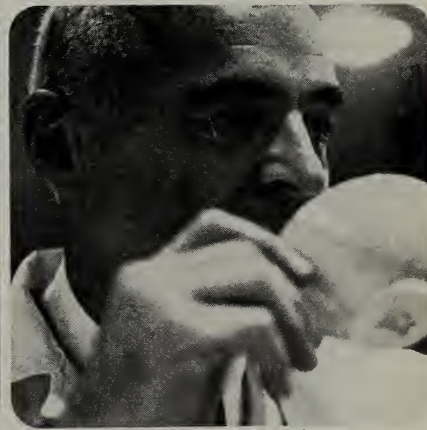
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women work in that organization's testing program in the Columbus public schools, the parochial schools and the county schools. Auxiliary members deliver material such as forms to be filled out, permission slips and instructions to the school nurses two weeks prior to the testing date. Last year, 10,471 children were tested in 178 schools. The most recent program started this past October and will continue four days each week until May.

In addition to informative speakers at the regular meetings of the Franklin Auxiliary, the group has had displays relating to mental health, international health and international relations. November featured a "Fantasy in Foods" — foods of Persia, Germany, China, Italy, Sweden as well as Jewish dishes and American buffet and holiday delicacies. The tables displaying this unusual culinary array emphasized the motif and decor of the particular national background.

In January, members exhibited their own works of art in paintings, sculpture and ceramics. The February meeting highlighted antique medical equipment — "You Couldn't Get It Wholesale." There certainly seems to be plenty of doctors' wives' activity in our state capital!

#### "Senior Volunteers"

That's the name of the newest project of the Hamilton County Auxiliary—a recruiting and placement service for retired people. Launched recently under the co-sponsorship of the Volunteer Bureau of the United Appeal agency, the service seeks to place alert retirees and other mature adults in volunteer jobs on a level with their talents and experience. The headquarters office is being staffed by doctors' wives, under the chairmanship of Mrs. George D. Griffin.

With approximately 110,000 older people living in the metropolitan area, the service sees no limit to the matching of volunteer jobs and talent. Openings are being recorded on file cards and classified with colored tabs for quick reference. Recruitment

will be a continuing effort through contacts with physicians, churches, industry, unions and senior citizens' organizations. Interview hours are now from 10 a. m. to noon on Mondays, Wednesdays and Fridays, but as the pioneer project expands, the hours will be extended.

Working with Mrs. Griffin are: Mrs. Edward Bender, Mrs. John Fleming, Mrs. Paul Foldes, Mrs. Spencer Hagen, Mrs. George Haydon, Mrs. David Heusinkveld, Mrs. Fernand Siegel, Mrs. Donald Thomas, Mrs. Richard Weber and Mrs. Robert Woolford.

#### All About Mrs. Van Epps

The *Daily Reporter* of Dover-New Philadelphia recently ran a feature story on President-Elect Mary Louise Van Epps. Written by the Women's Page editor, it caught the warmth of our president-elect's personality and projected it deftly and interestingly. It did something else too. In telling Mary Louise's story, it competently sketched in the story of the doctors' wives' auxiliary. That is publicity at its best.

The January meeting of the Tuscarawas Auxiliary was held at the home of Mrs. J. R. Martin in Dover. The business meeting was conducted by Mrs. E. R. Hammersley, president, who announced that the local group would be hostess at one of the State Convention luncheons in May. Mrs. Roy Wilson, AMA-ERF chairman, revealed contributions of \$2,108 realized through the sale of Christmas candy, note paper, bracelets and the generosity of the county physicians.

For the evening's program, Mr. Doyle Stone of the House of Stones in New Philadelphia presented an interesting and informative talk on diamonds, displaying rough gems from South Africa as well as cut stones and mountings. Even the refreshment table used as its decorative center an arrangement of stones from various parts of the country. The unusual centerpiece was the work of Mrs. Burrell Russell. Serving on the evening's committee were Mrs. Martin, Mrs. Russell, Mrs. L. L. Appel, Mrs. Jurgin Balciuness and Mrs. Harold F. Wherley.



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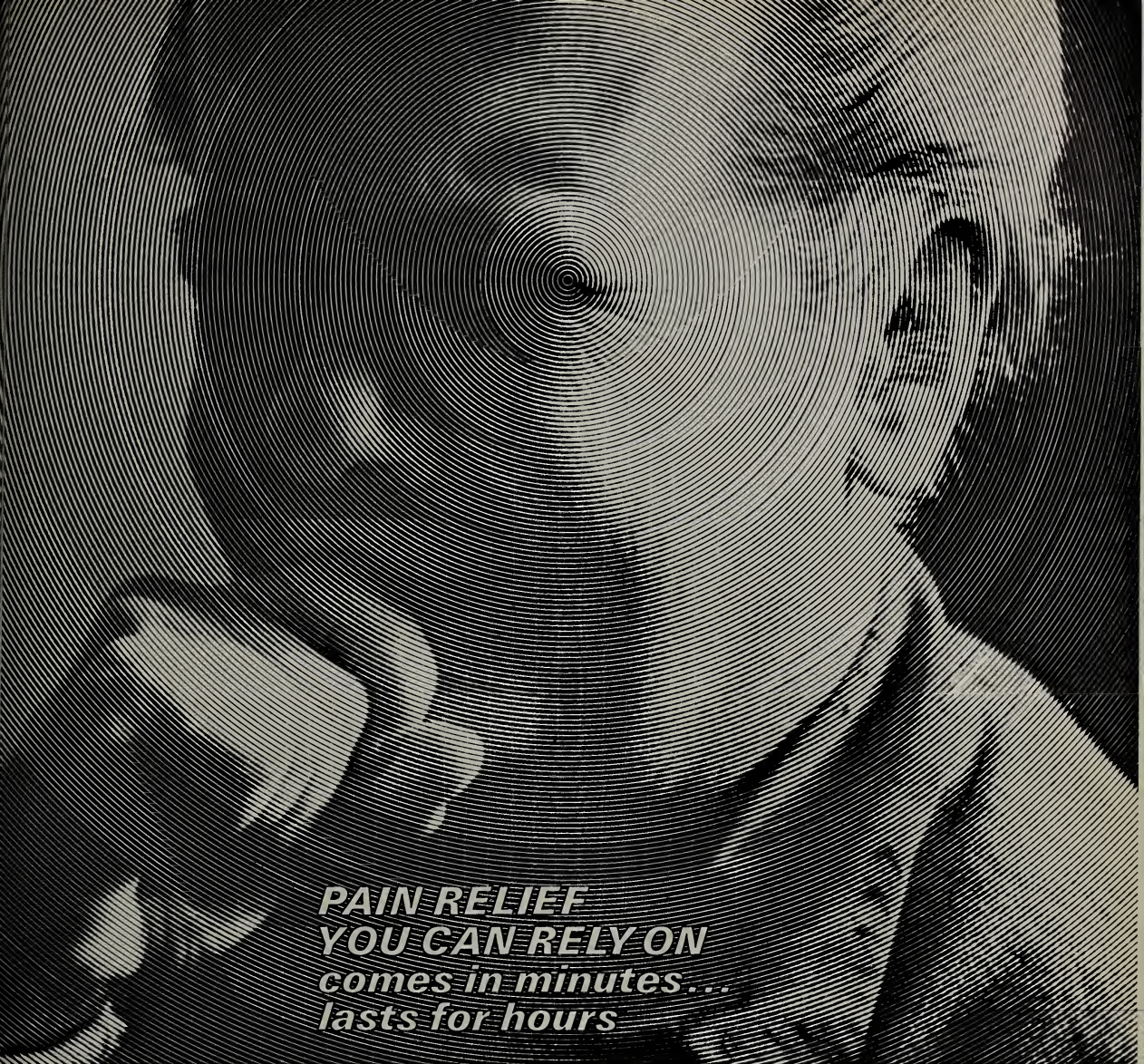
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## STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

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**Committee on Radiation**—Charles M. Barrett, Cincinnati, Chairman; Eldred B. Heisel, Columbus; George F. Jones, Lancaster; Carey B. Paul, Jr., Columbus; Thomas C. Pomeroy, Columbus; Denis A. Radefeld, Lorain; Eugene L. Saenger, Cincinnati; Robert E. Schulz, Wooster; John P. Storaasli, Cleveland; Robert P. Ulrich, Troy; Robert L. Wall, Columbus; John Robert Yoder, Toledo; James G. Kereiakes, Ph.D. (Advisory Member, Special Consultant), Cincinnati.

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**Committee on School Health**—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Paul D. Hahn, New Philadelphia; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Lawrence L. Maggiano, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Albert E. Thielen, Cincinnati; Homer B. Thomas, Gallipolis.

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### DELEGATES AND ALTERNATES

**Delegates and Alternates to the American Medical Association**—George W. Petznick, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Theodore L. Light, Dayton; Kenneth D. Arn, Dayton, alternate; Edmond K. Yantes, Wilmington; Harry K. Hines, Cincinnati, alternate; John H. Budd, Cleveland; P. John Robeck, Cleveland, alternate; Richard L. Meiling, Columbus; Robert E. Tschantz, Canton, alternate; Paul F. Orr, Perrysburg; Frederick P. Osgood, Toledo, alternate; Charles A. Sebastian, Cincinnati; J. Robert Hudson, Cincinnati, alternate; Edwin H. Artman, Chillicothe; Philip B. Hardymon, Columbus, alternate.

## COUNTY SOCIETIES' OFFICERS AND MEETING DATES

### First District

Councillor: Robert E. Howard, Cincinnati 43202  
2600 Union Central Bldg.

**ADAMS**—Hazel L. Sproull, President, 113 E. Mulberry St., West Union; Kenneth C. Jee, Secretary, Winchester.  
**BROWN**—John A. Powell, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown. 3rd Sunday, monthly.  
**BUTLER**—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton. 4th Wednesday.  
**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.  
**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p.m., monthly, Clinton Memorial Hospital.  
**HAMILTON**—John J. Cranley, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.  
**HIGHLAND**—Walter Felson, President, 357 South St., Greenfield; Thomas Jones, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.  
**WARREN**—Dale D. Hubbard, President, 116 Warren Ave., Franklin; D. Paul Ward, Secretary, Box 18, Pleasant Plain. 2nd Tuesday, monthly.

### Second District

Councillor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

**CHAMPAIGN**—Isador Miller, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.  
**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.  
**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, 29 East Wood Street, Versailles. 3rd Tuesday, monthly.  
**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.  
**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.  
**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.  
**PHELPS**—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.  
**SHELBY**—George J. Schroer, President, 322 Second Ave., Sidney; Alfonsoas Kisieliuss, Secretary, Ohio Building, Sidney. 2nd Tuesday, monthly.

### Third District

Councillor: Frederick T. Merchant, Marion 43301  
1051 Harding Memorial Pky.

**ALLEN**—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima. 3rd Tuesday, monthly, except June, July and August.  
**AUGLAIZE**—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 233, New Knoxville. Called meetings.  
**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.  
**HANCOCK**—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.  
**HARDIN**—Glen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center. 2nd Tuesday, monthly, except June, July and August.  
**LOGAN**—Richard A. Firmin, President, Zanesfield; Ernest J. Henson, Secretary, 128 W. Baird St., West Liberty. 1st Friday, monthly.  
**MARION**—James A. McGlew, President, 399 E. Church St., Marion; Lester E. Wall, Secretary, 317 S. Main St., Marion. 1st Tuesday, monthly.  
**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.  
**SENECA**—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.  
**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.  
**WYANDOT**—Franklin M. Smith, President, E. Saffle Ave., Box 68, Sycamore; Robert E. Goynse, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

### Fourth District

Councillor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

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**FULTON**—Benjamin H. Reed, Jr., President, 101 Adrian St., Delta; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon. 2nd Tuesday, March, June, September and December.  
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**LUCAS**—R. Philip Whitehead, President, 424 W. Woodruff Ave., Toledo 43602; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday.  
**OTTAWA**—Robert Reeves, Port Clinton Road, Oak Harbor; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Laura at Merrin, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. 3rd Wednesday, monthly.

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**SANDUSKY**—J. L. Zimmerman, President, Memorial Hospital, Fremont; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.

**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

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10525 Carnegie Ave.

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**CUYAHOGA**—Middleton H. Lambright, Jr., President, 10616 Euclid Avenue, Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland, 6.

**GEAUGA**—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

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438 North Park Ave.

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**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.

**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARK**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 44702. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

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**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.

**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

**MONROE**—Ronald E. Christman, Jr., President, 104 N. Sycamore St., Woodsfield; Byron Gillespie, Secretary, South Main St., Woodsfield.

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**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Seneca; Dayle O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.

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**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.

**WASHINGTON**—Tusath Patrick O'Maille, President, Marietta Memorial Hospital, Marietta; Richard R. Hille, Secretary 323 Second St., Marietta.

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2213 S. 9th St.

**GALLIA**—Isom C. Walker, Jr., M.D., President; Holzer Hospital, Gallipolis; Gene H. Abels, Secretary, Holzer Hospital, Gallipolis. Quarterly meetings.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

**JACKSON**—Carl J. Greever, President, 25 E. South St., Jackson; John E. MacLennan, Secretary, Oak Hill Hospital, Oak Hill. Called meetings.

**LAWRENCE**—Valley W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

**MEIGS**—Selim J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once monthly.

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**SCIOTO**—William E. Dachler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

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1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

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**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

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**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

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Councilor: L. C. Meredith, Jr., Elyria  
205 Elyria Block

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Clem, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.

**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P.O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

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**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.

**MEDINA**—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Stanley L. Brody, President, 327 Park Ave. W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.



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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus, Ohio 43215

**Physicians seeking locations in Ohio** are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

**G. P. WANTED AT ONCE** to take over established practice. Excellent small town — Cleveland area. Modern hospital. Attractive opportunity. Box 326, c/o Ohio State Medical Journal.

**FOR RENT:** Office suite. New Medical Bldg. Modern; on one floor; parking space; air conditioned. Call 442-0106 (Cleveland).

**G. P. WANTED** at once to take over established practice of 41 years; excellent small town in Toledo area; fine hospitals; attractive opportunity. Box 363, c/o Ohio State Medical Journal.

**NEEDED — General Physician — Family Internist** by four man group in growing rural program in West Virginia. Modern clinic facilities, regularly visiting specialist consultant staff, scheduled training and vacation periods, foundation sponsorship, no investment required. Starting net income range \$14,000 - \$18,000 depending on qualifications. Box 383, c/o Ohio State Medical Journal.

**WANTED:** One or two physicians to rent or buy on easy terms a modern brick, air-conditioned office with three-room living annex. Northwest Ohio, population 5000, within easy reach of hospital. No other doctor in town. Apply, Fred Chambers, President, The Troy Company, Luckey, Ohio; Phone 419-833-2001.

**GENERAL PRACTICE AND ANESTHESIA:** 40 Year old Cincinnati graduate, board eligible in anesthesiology and experienced general practitioner wishes to relocate in Ohio. Desires to do general practice (excluding obstetrics and surgery), and anesthesia. Would like to share expenses and coverage with another M.D. Box 397, c/o Ohio State Medical Journal.

**EXCELLENT OPPORTUNITY** for doctor to do general practice in a fine community (area of approximately 10,000 people). New 28 bed hospital. Will assist interested doctor to locate in area. For further information write to: Southern Lorain County Hospital, Wellington, Ohio.

**PSYCHIATRIC RESIDENCIES** available for now and July 1965 — approved 3-year progressive program near Detroit. University Association. Teaching staff of Board men, professors, psychoanalysts, nationally-known visiting lecturers. Active research. Modern physical plant. Stipends: 1st year, \$7,517; 2nd year, \$7,851; 3rd year, \$8,519 plus liberal vacation, sick leave, insurance benefits. GPs may apply for NIMH grant with stipends of \$12,000, available July 1965. 5-year career program with salaries from \$8,519 to \$15,723 also available. Write: Philip N. Brown, M.D., Superintendent, Northville State Hospital, Northville, Michigan. An equal opportunity employer.

**OFFICE AND EQUIPMENT FOR SALE:** General practice office for 7 yrs. at 1025 N. Columbus St., Lancaster, Ohio; excellent location with ample parking space; building and lot, \$12,900; several thousand dollars worth of equipment in excellent condition at agreeable price. William J. Boswell, M.D., 821 Garden Drive, Huron, Ohio 44839.

**TWO GENERAL PRACTITIONERS** for Association consisting of General Practitioners and Specialists; new building with x-ray and laboratory; salary open; leads to partnership. Wyoming Medical Center, Cincinnati, Ohio 45215.

**GENERAL PRACTICE FOR SALE:** Modern office building with adjacent almost new 2-bedroom home in Bellefontaine. Open staff hospital. Leaving to specialize. Box 402, c/o Ohio State Medical Journal.

**COLUMBUS, OHIO:** Office space and/or medical practice available on east side. Three-year lease. Box 403, c/o Ohio State Medical Journal.

**SHERWOOD, OHIO:** Modern brick building, 6-room doctor's office; general practitioner of long standing recently deceased; hospitals within easy reach; convenient terms. Lee W. Moats, Box 7, Sherwood, Ohio; Phone 899-4255.

**GENERAL PRACTICE FOR SALE** near Columbus, Ohio, July, 1965. Modern Hospital with open staff. Attractive terms. Leaving to specialize. Box 404, c/o Ohio State Medical Journal.

**UROLOGY EQUIPMENT FOR SALE:** Closing out office; equipment, furniture, instruments; all modern. Box 406, c/o Ohio State Medical Journal.

**PSYCHIATRIC RESIDENCY AND STAFF POSITIONS** available — Appointments available at all levels for residency in three-year approved dynamic program in psychiatry. 2100-bed hospital with affiliated community service clinic, child psychiatry and psychosomatic medicine; individual and group psychotherapy under supervision of hospital staff and practicing psychiatrists in the community; organized didactic training in basic sciences, clinical neurology and psychiatry; hospital participates in visitors and exchange program; foreign graduates must be ECFMG certified; all Ohio Civil Service benefits including vacation, sick leave, retirement program; new pay scale effective January, 1965. Three years program: \$8,000-\$10,000 yearly; 5 years career program: \$11,000-\$16,000 yearly; those with 4 years private practice: \$12,000-\$14,000 annually. Staff psychiatrists wanted for positions paying from \$16,000 and up. Write: G. I. Podobnikar, M.D., Director, Education and Training, Columbus State Hospital, 1960 West Broad Street, Columbus, Ohio 43225.

**WANTED AN ASSOCIATE IN GENERAL PRACTICE:** Practice well established for 10 years; salary first year with partnership thereafter. No investment required. Small community with excellent hospital. Box 405, c/o Ohio State Medical Journal.

**WELL-ESTABLISHED Medical Practice** for sale in Lorain, Ohio, by physician's widow. No capital needed for the first year. Contact Mrs. Elizabeth Varga-Sinka, 2891 E. Erie Ave., Lorain, Ohio, or call Lorain, BRoadway 7-8268.

**RESIDENCIES, PSYCHIATRY (GP PROGRAM):** The Ohio State University College of Medicine, Department of Psychiatry, has vacancies for two residents beginning July 1, 1965, in the NIMH-supported program for psychiatric training of non-psychiatric physicians who have been in practice four or more years and under 45 years of age. Three year approved program is multi-disciplinary in approach, centered in the University Psychiatric Hospital of 128 beds with out-patient services and large research organization. Stipends are \$10,000, \$11,000, and \$12,000 in first, second and third years respectively. Apply to: R. M. Patterson, M.D., Chairman, Department of Psychiatry, Upham Hall, 410 West Tenth Avenue, Columbus, Ohio 43210.

**FOR RENT:** Office of Cleveland G. P. deceased; fully equipped; 35 years established neighborhood practice; patients' records available. Box 398, c/o Ohio State Medical Journal.

**RURAL-SUBURBAN COMMUNITY** needs a General Physician. Will build a new Medical Center to doctor's specifications, with option to rent, lease, or buy. Within 10 miles from a new 96-bed hospital. Community of 2300 families in a growing area. New consolidated High School within 4 miles. Write Warsaw Lions Club, c/o Marvin Davis, Box 66, Warsaw, Ohio 43844. Phone 614-824-2421.

**GENERAL PRACTICE OFFICE FOR SALE.** Air conditioned, 5 rooms, carpeted, excellent location, large parking lot, records included; near 3 hospitals, close to excellent residential area; leaving to specialize in July. Phone 895-4541, Hamilton, Ohio.

**ANESTHESIOLOGIST** wishes to practice full time Anesthesia in Ohio. Standard Certificate E.C.F.M.G., U. S. citizenship, Ohio licensed; three years approved complete training, several years of experience, good references. Box 409, c/o Ohio State Medical Journal.

**FOR SALE IN MARION, OHIO:** Duplex, combination office-residence, including all medical equipment and instruments; downstairs six rooms used as professional quarters by doctor recently deceased. Upper six rooms for residence or professional use. Hot water heat throughout; first floor air-conditioned. Mrs. Berenice C. Boxwell, 760 Harvey Drive, Marion, Ohio 43305.

**FOR SALE:** Practice for general surgeon or GP in Columbus, due to death of physician; well-established; records, furniture, equipment, instruments, etc.; good clientele; office on rental basis; assured hospital affiliation. Phone: CA 1-4068, during office hours.

**RETIRING PHYSICIAN** wants a well qualified, personable physician, either an Internist or G.P., to take over a very active practice in the Akron area. To rent or lease a large first floor office in a very good location. Box 407, c/o Ohio State Medical Journal.

**WANTED INTERNIST** to join well established 5-man group in town of 10,000 located in progressive area of 90,000; good pay, good living conditions. For particulars, contact Alex Shadid, M.D., Medical Director, Community Hospital-Clinic, Elk City, Oklahoma.

(More Ads on Facing Page)



## Classified Advertisements (Contd.)

**EAR, NOSE and THROAT PRACTICE:** The fully equipped and recently redecorated office of a deceased ENT specialist in a modern medical building in the heart of Cleveland's western suburbs is available for immediate sale. The office was newly re-equipped in 1964, and had proved to be an outstanding opportunity. For further information write or call Edmund Durkin, Jr., 1857 Union Commerce Building, Cleveland 14, Ohio. Phone 216-621-5620.

**OBSTETRICS and GYNECOLOGY:** 3-year residency completed July 1965. Would like association leading to partnership. Box 408, c/o Ohio State Medical Journal.

**FOR SALE:** Sedgwick heavy duty chair stairway elevator. One year old. Half price. Edward L. Voke, M. D., 318 Ohio Building, Akron 8, Ohio.

**WANTED:** Associate in Internal Medicine. Community serving 75,000. Excellent Hospital. Box 410, The Ohio State Medical Journal.

**M. D. LICENSED IN OHIO** to join an expanding Emergency Room group. Opportunity offers regular hours with adequate time off, no overhead, excellent income on a fee-for-service basis and daily contact with medical specialists. A young, progressive suburban community with excellent schools, recreational facilities, churches close to the center of Cleveland. Contact A. C. O'Connor, Administrator, Parma Community General Hospital, Parma, Ohio.

**CINCINNATI AREA — MARIEMONT:** Office for lease. This location has been a physician's office for 34 years. Near a very fine hospital. Write L. Hermanies, 3900 Oak St., Mariemont, Cincinnati, Ohio 45227; Telephone 271-0291.

### A Critical Look at the Dilemma Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

\* \* \*

This relationship of drug manufacturers, government, and individual investigators is a difficult one. I strongly believe that all of us must want to make it a workable and fair one. It is time the FDA quit acting as policemen too ready to hand out a ticket and for manufacturers to be on their guard against overstepping reasonable bounds in their desire to promote a product. We physicians should make every effort through the American Medical Association and the physiological, clinical, and pharmacological societies to express considered points of view and help keep the peace as well. Our patient's good health and his solvency are at stake. — Irvine H. Page, M. D., in *Modern Medicine*, 32:25, (Dec.) 1964.

\* \* \*

One of the best buys (if indeed not *the* best) in our country today is the purchase of drugs. Considering what one gets for his money, namely, better health and/or less suffering, the cost is most usually well worth every penny spent. It is most unfortunate though that many people believe quite differently. Whatever their reason may be, there frequently lies hidden that unpleasant fact of paying for an unwanted event. — Joseph P. Schaefer, in *New Physician*, 14:1, (Jan.) 1965.

\* \* \*

Legislation that is conceived and enacted in an atmosphere of panic is usually ill-advised and may be disastrous. This statement applies to the passage of the Kefauver-Harris amendments to the Food, Drug and Cosmetic Act. It had its origin in the hysteria and panic of the thalidomide tragedy, it was nurtured and developed in the pandemonium of the biased hearings before the Kefauver Committee of the Senate, and through the pressure of an impetuous administration, was enacted into law. — John C. Krantz, Jr., Ph. D., in *Military Medicine*, 130:1, (Jan.) 1965.

### New Members...

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during January. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

#### Adams

Beverly Lafferty, West Union  
William Lafferty, West Union

#### Athens

Floyd Bajjaly, Athens

#### Belmont

James P. Antalis,  
Powhatan Point  
Frank J. Keefer, St. Clairsville

#### Champaign

Terrence F. Grogan, Urbana

#### Clermont

Alan D. Berenson, Milford

#### Erie

Jack Vermeeren, Sandusky

#### Hancock

Carson P. Cochran, Findlay  
Frank R. Costiano, Findlay  
James A. Miller, Findlay  
Richard W. Thomas, Findlay

#### Knox

Bala Mangru, Mt. Vernon

#### Lake

Philip Goldberg, Willowick

#### Lorain

Kenneth O'Connor, Elyria

#### Mahoning

Samuel G. Adornato,  
Youngstown  
Demetrios J. Dallis,  
Youngstown  
James R. Hill, Youngstown  
Isadore Mendel, Youngstown  
Milosav Petrovich,  
Youngstown

#### Marion

John E. Aiken, Marion  
Leopoldo Gonzalez, Marion  
Stavros E. Meimardis,  
Prospect

#### Miami

Elihu R. Morlidge, Jr.,  
Tipp City  
Lloyd G. Plummer, Troy

#### Ottawa

William T. Coon,  
Port Clinton

#### Portage

James J. Waugh, Kent

#### Scioto

Joseph J. Trevino, Portsmouth

#### Stark

Richard E. Easler, Canton

#### Summit

Richard E. May, Akron

#### Wayne

Paul H. Schraer, Orrville

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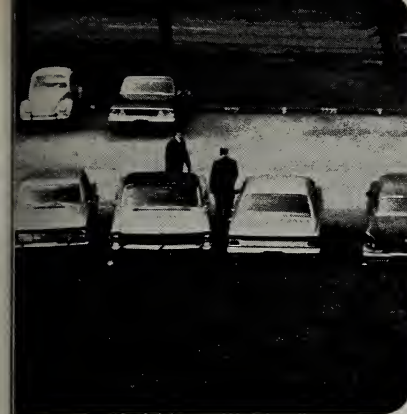
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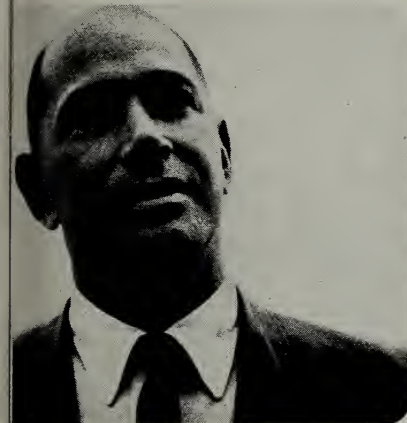
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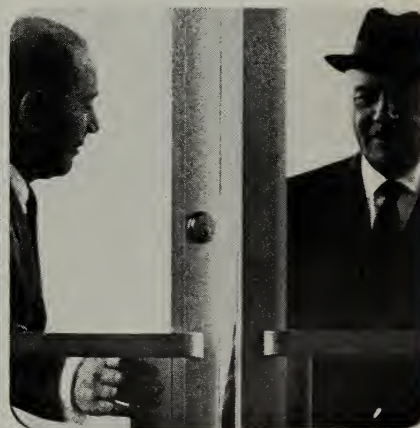
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**Warning:** Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs.

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severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

**Side Effects:** Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

For full details, see the complete prescribing information.

**Average Dosage:** One tablet daily with breakfast.  
**Availability:** Bottles of 100 and 1000 tablets.

\*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14-19, 1964.

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Division of Geigy Chemical Corporation  
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## Abstracts Being Received for October Heart Program

A one-day scientific session on stroke will be featured in the program of the American Heart Association's 1965 Scientific Sessions, to be held October 15-17 at the Americana Hotel, Bal Harbour, Florida. The session on Stroke will take place Saturday, October 16.

Neurologists, neuropathologists and neurosurgeons are invited to submit abstracts of papers for this session, according to Dr. John A. Rogers, president, Ohio State Heart Association, an affiliate of the national heart group. Deadline for receipt of abstracts at AHA is May 15.

Although previous AHA Scientific Sessions have included sessions on Stroke for the clinician primarily, Dr. Rogers points out, the 1965 event will emphasize the presentation of original investigative work in the cerebrovascular field.

Abstracts should be based on original investigations related to cerebrovascular disease. Forms may be obtained from Richard E. Hurley, M.D., American Heart Association, 44 East 23rd Street, New York, New York 10010.

## Course on Thyroid Disease Offered in Cleveland

The Cleveland Clinic Education Foundation is offering a postgraduate continuation course in endocrinology entitled "Recent Advances in the Diagnosis and Treatment of Thyroid Disease" April 14-15. The faculty will consist of members of the staff plus several guest speakers.

The course is approved for 12 credit hours category I by the American Academy of General Practice. Additional information may be obtained from the Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

## Physical Therapy Association Plans Cleveland Program

The 42nd Annual Conference of the American Physical Therapy Association will be held June 27 - July 2 in Cleveland, with headquarters in the Sheraton-Cleveland Hotel.

Additional information and data on registration may be obtained from the American Physical Therapy Association, 1790 Broadway, New York, N. Y. 10019.

The Ohio State Chapter may be addressed at 1875 Forest Hills Blvd., Cleveland, Ohio 44112.

Dr. Robert L. Wall, associate professor in the Ohio State University College of Medicine, was on the program of the American College of Physicians for its recent Chicago meeting. His topic was, "Christmas Disease, Color Blindness and the Xg<sup>a</sup> Blood group in the Amish."

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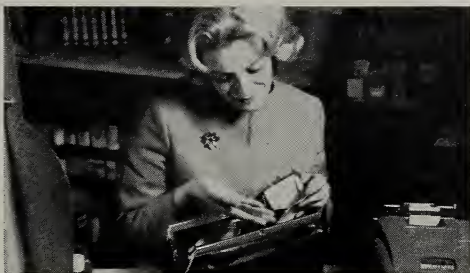


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## Largest AMA Convention Scheduled In New York, June 20-24

The American Medical Association's 114th Annual Convention, June 20-24, in New York City is expected to be the largest in AMA history.

The largest previous AMA convention was in 1961 in New York City when 46,679 attended, including 23,083 physicians. The 1965 Convention is expected to be much larger.

A diverse scientific program covering virtually every medical specialty will be presented, according to Gilson Colby Engel, M. D., Philadelphia, chairman of the AMA's Council on Postgraduate Programs.

Dr. Engel said the 1965 program will provide "outstanding educational opportunities for members of all fields of medicine, including specialists and general practitioners."

Six general scientific sessions will be coordinated by secretaries of various AMA specialty sections. Topics include hearing, adverse reactions, non-narcotic drug addiction, metabolism in growth development and aging, diagnostic cytology, and organ transplantation.

Another highlight will be the fifth Multiple Discipline Research Forum, presented this year as a program of the AMA Section on Experimental Medicine and Therapeutics. Edwin H. Ellison, M. D., Milwaukee, again is serving as forum chairman. Dr. Ellison

said that 60 reports based on research being done throughout the country will be presented.

AMA's other scientific sections also will present programs for physicians in their specialties. The more than 350 scientific exhibits will be housed in the New York Coliseum, which also will be the site of many scientific sessions as well as an extensive medical motion picture and television program.

The AMA's policy-making House of Delegates will meet in the Americana Hotel.

## Treatment of Psychiatric Patients in General Hospitals on Increase

The general hospital is now a facility of major significance in providing treatment for mental illness, according to figures announced by the Public Health Service.

A total of 1,005 general hospitals in the United States admit psychiatric patients for diagnosis and treatment, according to preliminary results of a current hospital survey completed by the National Institute of Mental Health and the American Hospital Association.

In a recent 12-month period, the hospitals report that they discharged 412,459 psychiatric patients.

Public State and county mental hospitals, by contrast, admitted 285,244 patients in 1963.

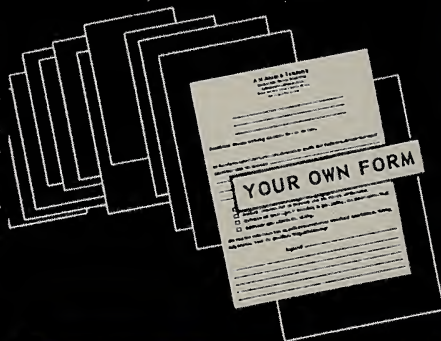
In Ohio, 45 general hospitals discharged (after treatment) 19,503 patients during the 12-month period.

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\* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

## A Critical Look at the Dilemma Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

\* \* \*

Several presidents of smaller companies have told me personally that they have abandoned all research efforts in the field of new drugs. They asserted that a small company cannot afford this type of research under the new regulations. And this is still an economy of free enterprise! The larger companies have not been able to create and market new chemical compounds with the same degree of efficiency as prior to the passage of the new law. This results in a definite curtailment of the total health progress of the nation for several reasons. — John C. Krantz, Jr., Ph. D., in *Military Medicine*, 130:1, (Jan.) 1965.

\* \* \*

It is common knowledge that the pharmaceutical industry is faced with a significant issue in the shortage of qualified investigators. Drugs are becoming more and more complex and the use of the general doctor, without specific experience in clinical investigation, in testing drugs in his office in the midst of a busy practice is probably coming to an end. The need for training of physicians in the drug research field has reached a critical stage, and this problem must be met by the joint efforts of government, industry, and the scientific community. — Joseph F. Sadusk, Jr., M. D., in *Bulletin of the American College of Physicians*, 5:6, (Nov.-Dec.) 1964.

\* \* \*

In my opinion, the pharmaceutical manufacturers have many opportunities to win the good-will and understanding of the medical profession. One of these opportunities for example pertains to the present dispute over the reporting of adverse side effects in journal ads and on drug labels. It seems to me that the industry has a point when it objects to excessive restrictions and argues that the medical profession receives adequate information about drugs through many channels now available. However, I believe that it could do a better educational job than it is presently doing, because many of my colleagues are still not convinced. For the future of medical practice and continued advances in pharmacological therapy, let's try to get to know each other better. — William L. Wheeler, Jr., M. D., in *Experimental Medicine and Surgery*, 22:2-3, (June-Sept.) 1964.

A three-day course directed to the surgical oriented physician will be held at the University of Wisconsin's Medical Center, in Madison, August 26-28, 1965.

**Indications:** Many types of edema involving retention of salt and water.

**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.

**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

**Average Dosage:** One tablet (100 mg.) daily with breakfast.

**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.

For full details, see the complete prescribing information.

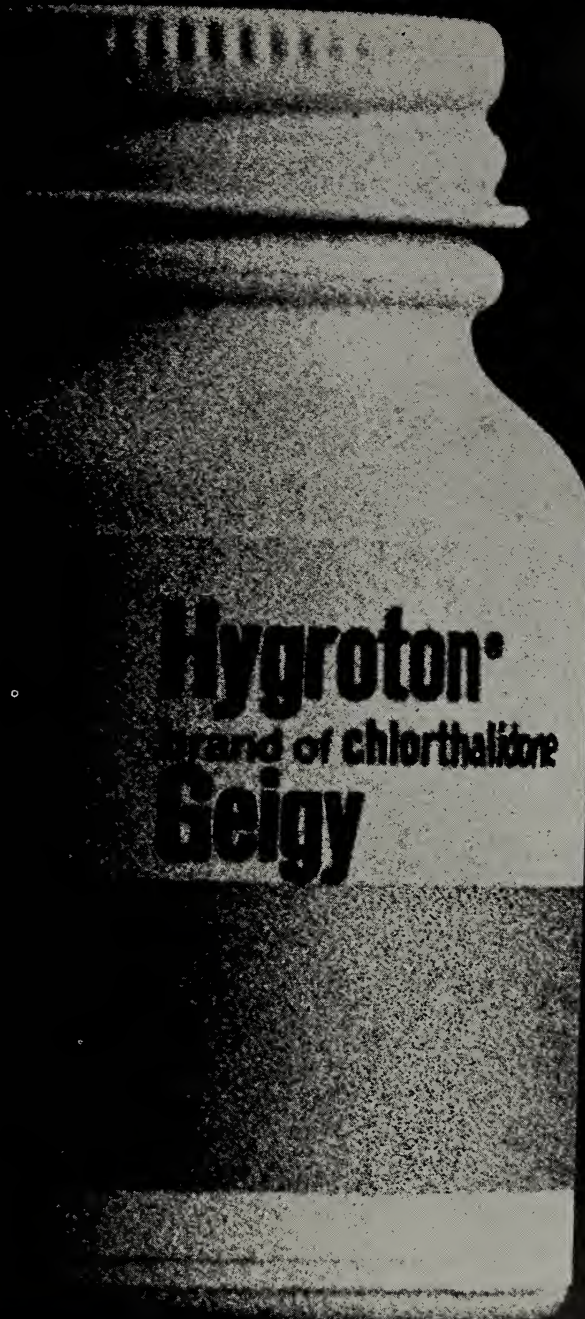


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Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220

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Each tablet contains:

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### a working analgesic for the active arthritic

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

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Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

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Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.<sup>1</sup>

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Each tablet contains:

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To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.<sup>2</sup>

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Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

**DOSAGE:** One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

**SIDE EFFECTS:** Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticism dictate reduction of dosage of Arthralgen-PR.

**PRECAUTION:** Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

**CONTRAINDICATIONS:** Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

**SUPPLY:** Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.  
2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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# Two Anatomists-Physicians Of the Old School:

Drs. John Maynard Wheaton and Josiah Medbery

LINDEN F. EDWARDS, Ph. D.\*

DURING the heyday of proprietary medical colleges, teachers of human anatomy almost without exception were physicians and/or surgeons who practiced their profession while at the same time serving as professor of anatomy. There were many "doctors," however, who played such a double role even though they were not graduates of a medical college and therefore lacked a M. D. degree, in spite of which they were permitted to practice up until they were prohibited from doing so by the enactment of laws imposed by State Medical Boards. It is also a well known fact that requirements for admission into many of these medical colleges were woefully inadequate, in some cases consisting only of the applicant's ability to read and write. Fortunately, on the other hand, there were many exceptions to such conditions, as well as to the lack of adequate background training, qualifications and ability of the professors in many of these institutions. Two such exceptions of anatomists-physicians of that era were the subjects of this paper — Drs. John M. Wheaton and Josiah Medbery.

The careers of Drs. Wheaton and Medbery illustrate a striking parallelism. Both were high school graduates, which was rather exceptional in that period of the 19th century, in that the majority of young people of their age terminated their schooling prior to or with the completion of the eighth grade; both attended Denison University; both obtained a B. A. degree before they entered medical college; both "read medicine," that is, served a preceptorship, under a noted Columbus physician; both graduated with a M. D. degree; both engaged in general practice in Columbus; both served as a Demonstrator of Anatomy and subsequently as a Professor of Anatomy in a Medical College in Columbus; and both were enthusiastic outdoorsmen.

\*Dr. Edwards, Columbus, is Professor of Anatomy, The Ohio State University College of Medicine.

Presented at the 12th Annual Meeting of the Ohio Academy of Medical History, April 18, 1964, at Granville, Ohio.

JOHN MAYNARD WHEATON, B. A., M. D.  
(1840-1887)

Dr. John Maynard Wheaton was a native of Columbus. He was born, lived out his career, and died in the same house, located at the N. E. corner of Fourth and Oak Streets, where he also maintained his office. He attended High School, at which time there was only one in the city, and from which he graduated at the age of 17. The following year he enrolled in Denison University and three years later graduated with a B. A. degree. He immediately began to "read medicine" under the well known Dr. Starling Loving of Columbus. Meanwhile he secured a position as a clerk in the office of the Adjutant General of Ohio and subsequently registered as a student in Starling Medical College, from which he graduated in 1865. For a time he served as an assistant surgeon in the 188th O. V. I.

When he returned to civilian life in 1866 he started in practice and shortly thereafter accepted an appointment as Demonstrator of Anatomy in Starling Medical College. Indicative of his ability as an anatomist was his promotion the following year to a Full Professorship of General and Descriptive Anatomy. In addition to his teaching duties and private practice he was elected a member of the Board of Trustees of the medical college and subsequently became Secretary of the Board. For several years he also served as Treasurer of the college.

He continued at the helm of Anatomy for 20 years, until his untimely death due to tuberculosis at the age of 46. He was acclaimed as a man of recognized ability as a teacher and one of the finest anatomists in the state. For many years the statement appeared in the catalogues of Starling Medical College that "It is the aim of Professor Wheaton to make the study of Anatomy so difficult and uninviting to many, attractive." That he was held in high esteem by the faculty and students of Starling Medical



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College is the fact that on the day of his funeral classes were dismissed and the faculty and students attended in a body.

### "His Hobby Brought Him Fame"

The statement has been made that Dr. Wheaton contributed to the scientific literature and was better known abroad than at home. A diligent search of the literature, however, has failed to verify this claim. One thing certain, though, is that he had a reputation as a naturalist of the highest order and was the leading ornithologist of Ohio. In fact, as one of his biographers put it, "his hobby brought him fame." As a youngster, he early became interested in collecting specimens of wildlife, especially butterflies, beetles, snakes, clams, and birds. For years he indulged in his hobby, and it is claimed his doctor's office resembled a museum because of his display of insects, reptiles, and mounted stuffed birds. Some amusing anecdotes are told about his collection of live snakes and of their escape from their cages into his office.

In 1882, the Geological Survey of Ohio published a list and description of his collection of birds, nearly 300 species of which he systematically arranged and described. This work is entitled *A Report on the Birds of Ohio* and is considered a classic, being recognized as the most complete report ever published on the subject. His collection is still extant and today his mounted birds are on display in the Hall of Birds of the Ohio State Museum. It is also of interest to mention that Dr. Wheaton's name is memorialized in Columbus to this day, as The Wheaton Ornithological Club, which was organized and named in his memory on October 19, 1896, and is still active.<sup>1-6</sup>

JOSIAH MEDBERY, B. A., M. A., M. D.  
(1853-1931)

Dr. Josiah Medbery, in contrast to Dr. Wheaton, was a country boy, born on a farm near Reynoldsburg, Franklin County, Ohio. He was a member of the first graduating class of Reynoldsburg High School, then called Academy, class of 1871. During the following two years he attended Denison University, after which he transferred to Brown University, Providence, Rhode Island. The reason for his change is not known, unless, perhaps, it was due to his father, who was a native of Rhode Island. Dr. Medbery graduated from Brown University with a B. A. degree in the spring of 1875 and that autumn he enrolled as a medical student at the University of Michigan. During that year, the Columbus Medical College was founded by a group of physicians who had previously served on the faculty of Starling Medical College. At the end of his first year in medicine, Dr. Medbery transferred to the newly organized Columbus Medical College, from which he graduated with a M. D. degree in 1878, meanwhile having read medicine under Dr. J. W. Hamilton, a noted physician of Columbus.

He opened an office for General Practice at 41 East Chestnut St., and in 1880 he was appointed Demonstrator of Anatomy in the Columbus Medical College. In 1882, he was promoted to Professor of Anatomy. In that year, he was also awarded a M. A. degree by Brown University. He continued to serve as Professor of Anatomy at the Columbus Medical College until 1890-1891. One year later, the college closed, after having survived only 17 years, during which time it graduated only about 500 students. Details concerning Dr. Medbery's career during the next few years are lacking, except to mention that, according to one source of information, he relinquished his medical practice in 1890 due to ill health.

### Taught Dental and Medical Students

In 1898, he accepted an appointment as Professor of Descriptive Anatomy in Ohio Medical University. He served in that capacity until 1907 when the University merged with Starling Medical College to form Starling-Ohio Medical College. He continued to serve in that institution as Professor of Human Anatomy until 1914, at which time the college was acquired by The Ohio State University, and Dr. Medbery retired, after having taught a total of 24 years. During his sojourn in Ohio Medical University and in Starling-Ohio Medical College he taught Human Anatomy to Dental as well as to Medical Students.

He was of that school of anatomists who believed that the primary function of an anatomy professor is to teach the subject. His reputation as an anatomist was very high, and he was regarded by his students with pronounced respect for his ability and for his willingness to assist them in every way. Many anecdotes have been told about incidents which happened in his classes and of clever tricks he used in teaching to get better work out of his students. If he conducted any research, he failed to publish his findings.

He was active in various fraternal organizations, and although he did not aspire to any political office, he was active in politics, at the county and state levels, and served as United States Pensioner Examiner in Columbus from 1889 to 1893.

He was an avid outdoorsman, fisherman, and hunter. He was one of the founders of The Blazed Trail Club, a hunting and fishing club near Steuben, Michigan, where he built a well-constructed log cabin on a beautiful site overlooking Hughes Lake. The log cabin and club are still in existence. Tradition has it that the club took its name from the title of a book written by Stewart Allen White while vacationing on the site several years ago.

### Brown University Pays Him a Tribute

Dr. Medbery's death occurred at his home, 30 Miami Avenue, Columbus, at the age of 78. The surviving members of his class of 1875 of Brown University after learning of his passing paid him a



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JOHN H. SMITHFIELD, M.D.

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fine tribute, stating among other things that they rejoiced in his fame as an outstanding teacher of Anatomy in the Middle West.

It is quite likely that today, according to modern standards with the great emphasis on scientific research, Drs. Wheaton and Medbery, regardless of their reputations as highly qualified and stimulating Professors of Human Anatomy, would be relegated to the rank of mediocrity due to their failure to have published any original contributions to the field of Anatomy or Medicine. It is possible, however, that the influence they exerted on their students might have borne more fruit over the years than any anatomical or medical papers they might have had published, especially if published just for the sake of receiving credit for publications. At least no charges can be brought against them of being guilty of having published premature or erroneous results.

One of the primary objectives of the present paper is to remind us to pay homage to former devoted

medical educators who combined their teaching with their practice; and to accord to them the honor and respect they so rightfully deserve for their efforts; and to be ever mindful of the fact that the value of their services as professors far exceeded their monetary compensation in proportion to modern day salary scales for comparable services.

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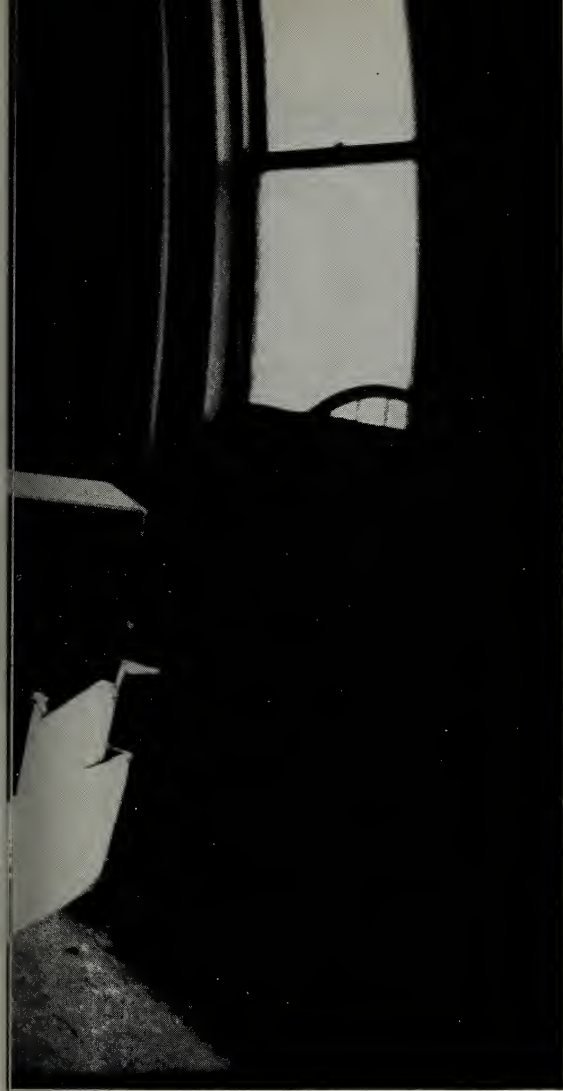
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10. Catalogues and Minutes of the Board of Trustees of Ohio Medical University, 1898-1906 and of Starling - Ohio Medical College, 1907-1913.

**I**NVENTION OF EYEGLASSES.— While it may not be possible to name the inventor, it is reasonably certain that glasses were first made in northern Italy shortly before the year 1300. None of the earliest spectacles has been preserved. Knowledge of them is derived largely from paintings of the period. A painting completed by Jan van Eyck in 1436 shows a canon in white robes holding a pair of spectacles. This was about four years before the accepted date of the invention of printing, at a time when few people outside the Church could read or write, and there was no widespread need for glasses. When this canon had his picture painted in the elaborate surroundings with the Madonna and Child, St. Donatus, and St. George, he had his glasses included to prove that he was truly a man of distinction. Benjamin Franklin is credited with the invention of bifocals.— **ABSTRACT:** C. Wilbur Rucker, M. D.: *Proceedings, Staff Meetings, Mayo Clinic*, 35:209, 1962.

**T**HE ART OF MEDICINE is a complex composite qualification acquired only through experience and long and intimate associations with people—the well and the sick—and their problems. It is composite because it is a mellow blending of many attributes which when fully exemplified in one person exhibit the sort of standard we as physicians would do well to emulate.

What are these attributes? Calling upon my experience with the art of medicine as practiced by those whom I admire—these attributes involve: the personal and professional approach to patients; the clinical development of the five senses; the maintenance of clinical and purely scientific aspects of the practice of medicine in their proper perspective; conservatism in therapy with special caution and critical evaluation of new forms of treatment and in this respect as an observer rather than an experimenter, and the careful use of words which after being emitted may change colors like the chameleon.—Garfield G. Duncan, M. D., Philadelphia, *Military Medicine*, 126:355-358, (May) 1961.





**Side effects and precautions:** The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution**  
**Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

## University Hospitals, Cleveland Plan Centennial Symposium

In keeping with the 100th anniversary of University Hospitals of Cleveland, "A Centennial Symposium" has been scheduled in University Circle for Thursday-Saturday, May 20-22. Chairman of the Symposium Planning Committee is Dr. Alan R. Moritz, director of pathology at University Hospitals, and vice-president of Western Reserve University.

Several departmental sessions are scheduled.

The Department of Medicine will present a program on Friday afternoon and grand rounds on Saturday morning, followed by a joint session with the Department of Pathology.

The Department of Pathology will present a program on Friday afternoon and Saturday morning followed by a Clinical Pathological Conference.

The Departments of Pediatrics, and Obstetrics and Gynecology have scheduled a program on Friday afternoon, with a pediatrics program also on Saturday morning.

The Department of Psychiatry is sponsoring a program on Friday afternoon.

The Department of Radiology is holding a program on Friday afternoon and Saturday morning.

The Department of Surgery is sponsoring a program on Friday afternoon and Saturday morning.

A program for nurses is scheduled on Friday afternoon.

Special events include a luncheon on Friday honoring Dr. Alan R. Moritz; a dinner dance on Friday evening at the Sheraton Cleveland Hotel; and a luncheon honoring Dr. Claude S. Beck on Saturday.

The Cleveland Medical Library devoted the January issue of its *Bulletin* to the history of University, beginning with a renovated frame residence building a hundred years ago. *The Plain Dealer*, of Cleveland, ran a feature article in its December 6 Sunday Magazine section, tracing the history of University Hospitals and projecting development toward completion of the \$54,800,000 expansion program now underway.

## Bureau of Workmen's Compensation Has Openings for Physicians

The Ohio Department of State Personnel has announced non-assembled open-competitive civil service examinations for Bureau of Workmen's Compensation physicians in classification titles I, II and III. These are salaried, career civil service positions.

Employees serving in these classifications do work related to the processing and adjudication of workmen's compensation claims, and perform other duties relating to workmen's compensation.

Examinations are open to U.S. citizens having qualifications for the positions indicated. Application forms or other information may be obtained from the Department of State Personnel, Ohio Departments Building, Columbus.



## "All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests: they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.







# Scientific Section

VOL. 61

APRIL, 1965

No. 4

## Coal Tar Pitch Paint Poisoning

### A Case Report of Poisoning from Hydrocide 500 With Some Experimental Observations

MANUEL TZAGOURNIS, M. D.

RECENTLY a painter who used "Hydrocide 500," a coal tar pitch paint, was admitted to University Hospital with a clinical picture of a hypoplastic anemia and severe diffuse neuropathy. The reported constituents of this paint were benzene, naphthalene, xylene, cresol, pyridine, toluene, anthracene, phenol, ammonia and thiophene.

The route of contact was both by skin and inhalation of vapors when it was utilized as a spray in a semi-closed environment. Although a mask was worn by the patient, he could appreciate the odor of the vapors. He also developed small areas of blistering about his mouth and eyes from direct contact with the droplets of the paint.

The following discussion is a case report of this poisoning and some observations made on rats exposed to the paint in the liquid and vapor forms. No similar intoxications with this paint has been reported.

#### Case Report

A 43 year old white man was first admitted to University Hospital August 23, 1961, because of hematemesis and epistaxis secondary to a hypoplastic marrow. The patient had been a painter for about five years prior to his admission, using, for the most part, standard commercial paints. Once or twice each month he used a coal tar pitch paint with a sprayer to paint large disposals or sewage tanks. One week prior to the onset of his illness, he sprayed this paint inside large tanks for four of the five working days. The weather was quite warm and the patient used the usual commercial masks; however, he noted areas about his face

#### *The Author*

- Dr. Tzagournis, Columbus, is Resident, Internal Medicine, The Ohio State University Hospital.

and eyes resembling first degree burns which blistered and then disappeared. He had a mild conjunctivitis and pain in his nares and mouth during the days on which he used this paint.

Two days after he finished this particular job, he noted the onset of cramping abdominal pain, diarrhea, headache, and dizzy spells. He was admitted to another hospital with epistaxis, hematemesis, melena, and weakness. While hospitalized there, he developed total alopecia, a maculopapular erythematous rash in the axilla and abdomen, and a staggering gait. A bone marrow examination showed a hypoplastic marrow and he received 8 units of blood. He improved temporarily and was referred to University Hospital.

On physical examination his vital signs were stable, a confluent erythematous rash was present, and he was bleeding from his nose. He had scalp alopecia and hypesthesia of the distal extremities with peripheral weakness, loss of the deep tendon reflexes, and diminished vibratory sensation. The remainder of the physical examination was normal.

A peripheral blood examination showed a white cell count of 725 per cu. mm. with 30 per cent polymorphonuclear leukocytes, 10 per cent basophils, and 60 per cent lymphocytes; erythrocyte count was 3.73 million per cu. mm., reticulocytes 0.1 per cent, and platelets 52,220 per cu. mm. The bone marrow was severely hypoplastic with only megakaryocytic regeneration evident.

Treatment consisting of blood transfusions, testosterone, prednisone, and vitamin therapy was instituted. His hematologic picture began to improve rapidly with sub-

sequent restoration of the peripheral blood and bone marrow to normal values. He remained afebrile throughout the hospitalization. His neurologic findings worsened, with evidence of a characteristic diffuse neuropathy. Peroneal nerve conduction velocities showed a decrease from a normal 44 meters per second to 26.8 meters per second, while the ulnar nerve remained normal. A spinal fluid examination was normal except for a total of 23 lymphocytes per cu. mm. Other routine laboratory data were normal, and the patient was discharged Sept. 16, 1961, with a diagnosis of hypoplastic anemia and toxic peripheral neuropathy. He was to continue physical therapy at his home.

### Second Admission

One week after discharge, the patient returned for his second admission with complaints of progressive weakness, anesthesia of the extremities, shortness of breath, and difficulty in swallowing. The physical examination was normal except for the neurologic findings. Cranial nerves 1 through 8 were intact. Sensation above the right tonsillar fossa was absent. The gag reflex was greatly diminished, and there was considerable difficulty in swallowing. The uvula was deviated to the right. Proprioception was absent in all extremities. Pain and discrimination were absent bilaterally distal to the knees and the elbows. There was virtually complete flaccid paralysis of the distal extremities with severe weakness of the shoulder, chest, abdominal and hip movements.

Shortly after admission he became increasingly dyspneic and could not take a deep breath. Atelectasis of the left lung developed, and the patient could not expectorate his secretions. A tracheostomy was performed, and he was put into a respirator. He was unable to breathe without the respirator for periods longer than one hour. He subsequently lost his speech and swallowing mechanisms completely.

Treatment consisted of supportive care, hydrocortisone, vitamins, and, later, British Anti-Lewisite (BAL), 100 mg. four times daily.

The blood examination was normal and remained so throughout his hospitalization. The urinalysis, blood urea nitrogen, and total proteins were within normal limits. The cerebral spinal fluid examination showed a normal protein content and no leukocytes. The Pandy test was positive. Poliomyelitis, Japanese B encephalitis, and Herpes Simplex viral tests were negative. Leptospirosis titers were nonreactive. Viral cultures of the cerebral spinal fluid were negative for mumps and the encephalitides. A repeat nerve velocity test showed greatly diminished values of 1.2 meters per second for the ulnar nerve and no response by the peroneal nerve.

Arsenic levels were determined in the hair, nails, and urine because of the similarity of this problem to those described in subacute arsenic intoxication. The urine arsenic values were within normal limits but the arsenic content of the nails and hair was greatly increased. The nails contained 260 micrograms per gram of arsenic (normal: less than 80 micrograms per gram), and the hair contained 570 micrograms per gram (normal: less than 0.5 micrograms per gram).

Two weeks after admission he was able to breathe without a respirator. He slowly regained his speech and swallowing mechanisms, and proximal muscle strength began to return. About one month after admission Mee's lines (transverse white striae of the nails) were noted about 5 mm. from the nail root.

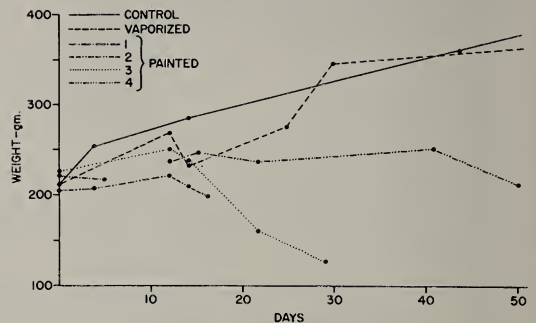
Over a period of about three months, he showed slow progressive improvement of strength and sensation in all muscle groups but still required braces to walk.

### Experimental Observations

A limited supply of the paint used by this patient was available, and its effects upon albino rats were observed. Four rats were painted with "Hydrocide 500" on the dorsal surfaces in areas varying in size from 2 inches square to 4 inches by 5 inches. Two rats were exposed to a paint-saturated atmosphere for periods of 15 minutes to six hours. This was

accomplished by placing the rat in a large, partially-covered flask which was sprayed with the paint through an atomizer. Two rats served as controls. At frequent intervals, weight, neurologic changes, behavior, and peripheral blood counts were evaluated. The "painted" rats had reapplication of the coal tar until they died, at 3 days, 14 days, 16 days, and 37 days. None of the others died.

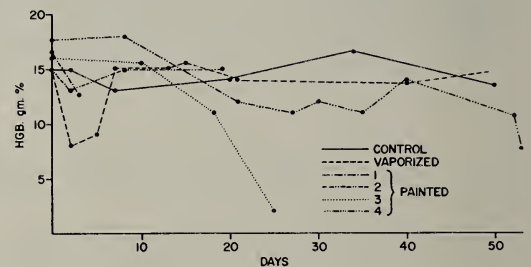
The weight records are depicted on Graph 1. The painted rats failed to gain weight after exposure to the paint. Those exposed to the vapor showed nor-



GRAPH 1. Weight records of rats used in the experiments. The painted rats failed to gain weight as compared to the control and vaporized rats.

mal weight gain. The control animals gained steadily throughout the experiment.

The hemoglobin determinations are shown on Graph 2. A noticeable decrease occurred in three of the four painted animals. The controls and the "vaporized" animals showed inconsequential changes except for one hemoglobin level which dropped to



GRAPH 2. Hemoglobin values of rats. After an initial decrease, the hemoglobin of the vaporized rat remained stable. Three of the four painted rats showed a decrease prior to their death.

9 grams per 100 ml., then recovered. The platelet count also was significantly altered as noted on Graph 3. One "vaporized" rat had a decrease to 83,600 platelets before beginning to recover. The two painted rats which lived for more than two weeks showed drops to 181,000 and 21,000 respectively before death, from normal levels of one to two million.

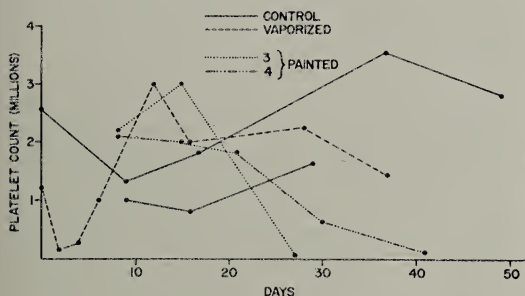
Other noteworthy observations included the neurologic findings which appeared in one painted rat.



Eight days after application of the paint, it developed a right hind leg weakness which progressed to decreased sensation and paralysis of that distal extremity. Considerable irritability was generally noted in the animal. About one week to 10 days later these neurologic symptoms improved prior to its death. Postmortem findings of atrophy of the Purkinje cells and petechial hemorrhages of the cortex and cerebellum were noted.

All the painted rats demonstrated marked alopecia in the painted area. As far distally as the tail there was shedding of the complete dermis in two of the rats.

Gross postmortem findings were not remarkable except for softening of the central nervous system tissue in one rat previously mentioned. Microscopic studies showed petechial hemorrhages in the brain, heart, lungs and liver. Decreased cellular activity in the bone marrow of two of the rats, acute necrosis



GRAPH 3. Platelet counts of rats. An initial decrease occurred in the count of the vaporized rat prior to obtaining a level effect. The two rats which died early did not have more than one platelet count and are, therefore, not included.

of lymphoid tissue of one rat, and hydropic degeneration of cells of the kidney and liver in another were noted.

No arsenic was found on analysis of the paint by The Kettering Laboratory, University of Cincinnati and Esso Research and Engineering Company. The livers of one painted rat and one control rat were sent to the Ohio State Health Laboratory for determination of arsenic levels. There were 5.2 micrograms of arsenic per 10 grams of tissue in the painted rat, almost nine times the 0.6 micrograms arsenic per 10 grams of liver in the control rat.

### Discussion

A difficult problem in diagnosis is presented to the clinician with a patient such as the one described in this paper. The history of exposure to a toxic hydrocarbon paint such as "Hydrocide 500," used as a spray in this case, necessitates the search for the specific etiologic agent involved. Since analysis of the paint is quite difficult for technical reasons, and basic information about the paint is lacking because of legal reasons, the problem of exact etiology is evident.

Intoxication from the aromatic and cyclic hydro-

carbons is certainly a consideration and perhaps even a potentiating catalyst in this case. As chronic poisons, the aromatic hydrocarbons such as benzene, toluene, xylene, and ethyl benzene have an almost specific effect on the hemopoietic system. These are widely used since they are good solvents for fats, oils, resins, rubbers, and bitumens.

Benzene, a coal tar derivative, is different from benzine, a petroleum distillate of variable chemical properties and compositions. Chronic benzene poisoning produces hemopoietic depression primarily because it is oxidized to the highly toxic forms of poly-phenols and hydroquinone. Toluene and xylene, on the other hand, are oxidized to less toxic compounds and therefore produce less hemopoietic depression. Benzene can also produce peripheral neuropathies, but reports of these are relatively rare.

Cresol, which usually comprises about 40 per cent tar derivatives and is a combination of ortho-, meta-, and para-hydroxytoluene, causes central nervous system depression and hepatorenal damage. Local manifestations produced are burning, reddening, and numbness which were evident in this patient on contact with the paint. The well known "lysol poisoning" is due to cresol.

Naphthalene, a bi-benzene compound, is a very toxic agent. Cutaneous exposure rarely causes systemic effects although dermatitis and ocular irritation may be severe. Hemolytic crisis constitutes the most spectacular reaction in intoxication, but liver necrosis, acute renal failure, central nervous system depression, and gastrointestinal symptoms occur not uncommonly.

Phenol, another compound in the paint, readily gains access to the body from all routes of administration including the intact skin. It is a general protoplasmic poison, and is toxic to all cells. In the chronic form of poisoning there is seen mild to moderate kidney damage, neuropathies, anemia, and loss of weight.

Pyridine is not absorbed readily from the skin but its vapors cause polyneuritis, facial paresis, headache, and hepatorenal damage.

Thiophene is of no importance toxicologically. Benzene vapors, when associated with a large percentage of benzene, were used by Sellings<sup>9</sup> on rabbits, and it is interesting to note that he was able to decrease the leukocytes in rabbits to almost zero and then watch them return to normal with a short rest period. In one of the "vaporized" rats in these experiments there was a decrease in the leukocyte count noted from a normal of 22,550 to 3,450 (which is very leukopenic for rats) which then returned to normal values six days later in spite of continuing exposure.

Clinically this patient resembled very closely the syndrome associated with subacute arsenic intoxication. It was found that hair and nail values for arsenic were very high in the patient. He also responded well to BAL. Experimentally, the painted

rat's liver contained nine times the arsenic of the control rat's liver.

Exposure to arsenic occurs among workers involved in various occupations such as the smelting of lead and copper, the insecticide industry, the glass industry, dye stuffs handlers, and the pharmaceutical industry, to mention the most obvious ones.

The site of action of arsenic is intracellular. The trivalent arsenic ion combines with the sulfhydryl groups and thus involves several enzyme systems. Therefore, BAL, which binds the arsenic more avidly than the sulfhydryl groups, is the principal agent used to treat these intoxications.

Acute arsenic intoxication frequently presents the clinical picture of nausea and vomiting with rice water diarrheal stools as the immediate symptoms. There may be headache, confusion, vertigo, drowsiness, convulsions, occasionally diplopia, and transient blindness. Neuropathy ensues one to three weeks later and skin changes occur one to six weeks later.

In the less acute forms of intoxication, a more insidious onset of malaise, fever, abdominal pain, pruritis, weakness and joint pain is likely. An erythematous morbilliform eczematous rash frequently occurs, followed by the characteristic skin lesions of hyperkeratosis and patchy areas of increased pigmentation. The central nervous system symptoms are not as prevalent in the subacute or chronic forms, but symmetrical polyneuritis occurs frequently. Only occasionally are the cranial nerves involved in arsenic poisoning. Mee's lines, the transverse white striae in the fingernails, appear 30 to 40 days after exposure. This sign can be used to determine the approximate time of exposure since it takes five to six months for a nail on the finger to grow from the cuticle to the tip of the finger. These lines are highly specific for arsenic intoxication but have been described in patients with lymphomas, Hodgkin's disease, and a few other entities. (See Fig. 1.)



FIG. 1. Mee's lines demonstrated by the patient.

Other symptoms and signs are vague gastrointestinal complaints, toxic hepatitis, aplastic anemias, total or incomplete alopecia, hematuria, frequency, and the development of skin carcinomas in subsequent years.

The most common pathologic manifestation of

chronic arsenic poisoning is degenerative changes in the peripheral nerves. Damaged capillaries in more acute cases account for the disseminated petechial effusions which are particularly prominent beneath the endocardium.

Many cases of arsenic causing peripheral neuropathy have been described. Heyman, et al.<sup>1</sup> reported 41 cases. Anemia and leukopenia were frequently found in the same patient but disappeared within three weeks. He also reported that one fifth of his patients had elevated protein but normal cell counts in the cerebral spinal fluid. He noted that BAL treatment usually produced an increased excretion of arsenic in the urine. None of his patients had cranial nerve involvements.

Another author<sup>14</sup> described six cases of chronic arsenic poisoning in which a distal distribution of motor and sensory lesions were observed. The symptoms were noted three to five months after the onset of intoxication and nasal bleeding with decreased peripheral red and white blood cells was quite prevalent.

### Summary

A case of poisoning from a coal tar pitch paint "Hydricide 500" is presented. The patient developed a hypoplastic anemia, bleeding, gastrointestinal symptoms, alopecia and a gradually progressive, severe polyneuropathy. Arsenic levels obtained on hair and nails were very suggestive of arsenic intoxication. Rats painted with the same material all died, showing evidence of anemia, thrombocytopenia, weight loss and one had a peripheral localized neuropathy. The liver of one painted rat contained nine times the arsenic content of the liver of the control rat. The other agents in the paint are discussed with regard to their individual toxicities. They probably contributed to the total clinical picture presented by the patient.

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# Bacteremia During Operative Procedures

## A Study of Incidence and Significance

MARTIN J. FISCHER, M. D., and FRANK W. AMES, M. D.

THIS study was undertaken to evaluate the incidence of bacteremia during operative procedures, to investigate its possible relationship to septic shock in the early postoperative period, and to draw retrospective conclusions regarding the use of prophylactic antibiotics in certain surgical procedures.

### Material and Methods

A total of 100 blood cultures were drawn. Twenty per cent were drawn in the operating room. In an effort to enhance recovery of bacteria, the cultures were drawn shortly after surgical manipulation of the organ being studied. Eighty per cent were drawn in the recovery room. Approximately two thirds of these were drawn within 10 minutes of arrival in the recovery room, the remainder within 30 minutes after arrival. The method of drawing blood cultures was the one in current use on the hospital floors by the bacteriology department. The skin was prepared for one to two minutes with 70 per cent alcohol. Autoclaved glass syringes and gas sterilized disposable 20-gauge needles were used. From 1 to 6 milliliters of blood was drawn from a large forearm vein and placed in a medium of 0.1 per cent tryptose phosphate broth, and incubated at 37° C. until positive or at least 21 days, if negative. Organisms recovered were identified, and sensitivity determinations were made, insofar as possible.

Case material classified according to type of operative procedure, can be summarized as follows:

I. <i>Nasopharyngeal</i>		
tonsillectomy	8	18 cases
other	10	
II. <i>Urinary tract</i>		28 cases
TUR prostate	10	
other	18	
III. <i>Gynecologic</i>		6 cases
IV. <i>Gastrointestinal</i>		40 cases
Gallbladder	}	13
common duct		
stomach		
colon		
rectal		5
other		5
V. <i>Miscellaneous</i>		8 cases
		100

### Results

Positive cultures were obtained from two of eight patients undergoing tonsillectomy. One yielded a

### The Authors

- Dr. Fischer, Akron, is third year resident in Surgery, Akron General Hospital.
- Dr. Ames, Akron, is co-chief resident in Medicine, Akron General Hospital.

coagulase negative *Staphylococcus*; this blood was drawn in the recovery room. The other yielded a group A *Streptococcus* and this blood was drawn in the operating room. Neither patient was receiving antibiotics. Both patients had uncomplicated postoperative courses. Cultures from the other six tonsillectomy patients were negative. Also negative were the 10 cultures drawn from patients undergoing dental extractions, submucous resections, rhinoplasties, bronchoscopies, and biopsies.

Enterococci were cultured from the blood of two patients undergoing transurethral resection (TUR) of the prostate. In both patients, similar organisms were recovered from the urine. One of these patients was receiving tetracycline, the other no antibiotic. Both specimens were drawn in the operating room. The other three blood cultures drawn during TUR of the prostate in the operating room were negative as were the six drawn in the recovery room after TUR. Eighteen cultures from other urologic patients were also negative. These included nephrectomies, suprapubic and retropubic prostatectomies, transurethral resection of bladder tumors, and cystoscopies with pyelography.

Cultures from all six patients undergoing gynecologic surgery were negative.

Of the 40 cultures from patients subjected to gastrointestinal surgery, only one was positive. This was drawn in the recovery room after hemorrhoidectomy. The patient had not received antibiotics. The organism was an unidentifiable gram-negative rod. Repeated attempts at subculturing were unsuccessful, suggesting the organism was of questionable significance. The negative cultures were from patients having cholecystectomy, common duct exploration,

operations on the stomach, colon, or rectum, drainage of intraperitoneal abscesses, and lysis of adhesions.

The miscellaneous cases included craniotomy, neck dissection, pulmonary exploration and resection, skin grafting, and herniorrhaphies. All cultures were negative save one drawn in the recovery room after incisional herniorrhaphy from which a coagulase negative *Staphylococcus* was recovered. The patient was not receiving antibiotics. Aside from a gram-negative urinary tract infection, his postoperative course was uneventful.

### Discussion

The finding of six positive cultures, of which only three are considered pathogenic, points to a relative infrequency of bacteremia during operative procedures. The fact that 32 per cent of the patients had been receiving antibiotics preoperatively may have lowered the yield, but probably not appreciably.

None of the patients with positive blood cultures suffered postoperative complications; sepsis was carefully looked for but did not occur. Two important conclusions may be drawn from these data. First, shock in the recovery room is rarely of septic etiology. Second, a positive blood culture obtained in the postoperative period does not reflect a continuation of an operative bacteremia and therefore should be treated (vigorously) as a septicemia. However, it would seem hazardous to conclude that operative bacteremia is always innocuous.

The recovery of a group A *Streptococcus* during tonsillectomy emphasizes again the need for anti-streptococcal antibiotic therapy after tonsillectomy.

The absence of bacteremia following the many operations on the gallbladder, common bile duct, stomach, and colon was noted. This evidence lends no support to the use of so-called prophylactic antibiotics following these procedures.

The incidence of bacteremia during transurethral resection of the prostate reported in the literature ranges from a low of 1 per cent<sup>1</sup> to a high of 55 per cent.<sup>2</sup> In all series,<sup>1,3-5</sup> the positive cultures were obtained in highest percentage from those patients with infected urine and/or those on preoperative catheter drainage. Bacteremia during this procedure has very important clinical implications. Postoperative septicemia is the single most common cause of death after both transurethral<sup>1,3</sup> and open resection<sup>5</sup> of the prostate. Marshall<sup>6</sup> demonstrated a higher mortality and morbidity rate among those with positive blood cultures. Creevy and Finney<sup>3</sup> found a higher incidence of postoperative infection and higher morbidity among patients with positive blood cultures during transurethral prostatic resection. Merritt<sup>7</sup> reported a 10 per cent incidence of bacterial endocarditis after TUR of the prostate in patients who had previous valvular cardiac disease.

These and other similar statistics have led many urologists to use antibiotics routinely before and after

transurethral prostatic resection. Creevy and Finney<sup>3</sup> reported halving the percentage of positive blood cultures, decreasing postoperative fever and infection, and a fivefold decrease in mortality with the use of broad spectrum antibiotics. However, Appleton and Waishren<sup>4</sup> found no effect of preoperative and postoperative chloramphenicol on the incidence of positive blood cultures and postoperative complications. The absence of postoperative complications in our patients with positive blood cultures, plus the fact that the blood culture was positive in one of two patients not receiving antibiotics and positive in only one of eight patients receiving antibiotics, serves only to heighten the controversy regarding antibiotic prophylaxis for transurethral prostatic resection.

### Summary and Conclusions

1. One hundred blood cultures were drawn from patients undergoing selected operative procedures, which were felt to have the highest possible incidence of operative bacteremia.
2. Positive blood cultures were obtained in 6 per cent.
3. Eighty cultures were drawn in the recovery room. Three were positive. Twenty cultures were drawn in the operating room. Three of these also were positive.
4. Organisms recovered were Enterococci from two transurethral prostatic resections, *Staphylococcus albus* and a group A *Streptococcus* from two tonsillectomies, a *Staph. albus* from a herniorrhaphy, and a gram-negative bacillus from a hemorrhoidectomy.
5. Since the patients with positive blood cultures suffered no postoperative complications, it may be concluded that shock in the recovery room is rarely due to sepsis, and secondly and most important, that positive blood cultures obtained after the immediate postoperative (recovery room) period are not bacteremias due to surgical manipulation, but are true septicemias and should be treated as such.
6. Evidence was obtained demonstrating the desirability of antibiotic prophylaxis in tonsillectomy and transurethral prostatic resection. No such evidence was obtained, within the limits of this study, for their use in gastrointestinal and biliary surgery.

**Acknowledgment:** The authors wish to thank Mr. Delbert Souders and Dr. James L. Beck for their many valuable suggestions and comments.

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# The Treatment of Bone Marrow Failure With Massive Androgen Therapy

WILK O. WEST, M. D.

ONE of the long established classes of hormonal substances recently has emerged as promising agents for the treatment of bone marrow failure. Androgens were first recognized as essential to normal erythropoiesis by McCullagh and Jones,<sup>1,2</sup> who showed that the administration of physiological doses of testosterone corrected the anemia of eunuchoid men. Erythropoietic responses to androgens subsequently were reported in isolated instances of severe endocrine conditions such as androgen deficiency,<sup>3,4</sup> hypopituitarism,<sup>4-6</sup> hypoadrenalism,<sup>3,4</sup> and myxedema.<sup>6,7</sup> Review of this literature suggests that androgen deficiency, per se, probably existed in all of these instances of endocrine disorder. Consequently, specific correction of the androgen deficiency in each instance could have explained the hematologic response noted.

McCullagh and Jones<sup>1,2</sup> suggested the trial of androgens as hematopoietic stimulants for various anemias, but apparently did not follow this line of investigation themselves. Testosterone was used in conventional doses by Rosenthal and Erf<sup>8</sup> and by Erf and Herbut<sup>9</sup> with limited therapeutic success in the treatment of myelofibrosis. The full hematopoiesis-stimulating potential of androgens first became apparent with the observation that polycythemic blood levels developed in patients who received massive doses of androgens for the control of breast carcinoma.

The theoretical basis for the use of pharmacologic doses of androgens as stimulants to hematopoiesis has been discussed at length by Kennedy and Gilbertson<sup>4</sup> and by Gardner and Pringle.<sup>3,10</sup> Such therapy has been found to be of significant value, primarily in the treatment of hypoplastic anemia<sup>3,11-13</sup> and myeloid metaplasia.<sup>3,4,8-10,14</sup> Less extensive experience has been reported on the use of androgens as hematopoietic stimulants in patients with lymphoma,<sup>3,15</sup> granulocytic leukemia,<sup>3</sup> lymphocytic leukemia,<sup>3</sup> multiple myeloma,<sup>3</sup> osteoporosis,<sup>3,4</sup> hemochromatosis,<sup>3</sup> paroxysmal nocturnal hemoglobinuria,<sup>3</sup> and achrestic anemia.<sup>5</sup>

The studies in this communication were initiated in

## The Author

● Dr. West, Lexington, Kentucky, is Hematologist, Section of Internal Medicine, Lexington Clinic; formerly, Chief Resident in Medicine (Hematology), Ohio State University Hospital, Columbus.

order to evaluate the use of massive androgen therapy in the management of hypoplastic anemia and myelofibrosis. Since the initial results suggested that there might be gratifying response to such therapy in patients with chronic lymphocytic leukemia who had become refractory because of bone marrow impaction, this became the principal interest of the present investigation. The opportunity also presented itself to evaluate androgen therapy in achrestic anemia.

## Materials and Methods

During the one-year period from July 1, 1959, to June 30, 1960, massive doses of androgens were administered to 68 patients at the Ohio State University Hospital and Clinic, Columbus, Ohio. In most instances this therapy was not begun until the patient had received an adequate trial of conventional therapeutic agents. During the latter few months of the investigation, however, androgens were given in the initial phases of treatment. The primary conditions treated are listed in Table 1.

TABLE 1. Primary Pathological Conditions in 68 Patients Exhibiting Refractory Bone Marrow Failure

Disease Category	Patients Beginning Therapy	Patients Completing Therapy	Patients Not Completing Therapy
Hypoplastic anemia .....	33	16	17
Primary myelofibrosis .....	9	7	2
Chronic Lymphocytic leukemia .....	21	18	3
Achrestic anemia .....	5	4	1
TOTALS .....	68	45	23

Parenteral treatment consisted of the administration of testosterone enanthate (Delatestryl\*) intramuscularly in the amount of 300 mg./week for a period of three months. This medication was given either as the commercial formulation containing 200

This paper, dedicated to my friend and teacher, the late Bruce K. Wiseman, M. D., was presented at the monthly meeting of the Columbus Academy of Internal Medicine, Columbus, Ohio, on May 31, 1960, and at the monthly Staff Meeting of the Lexington Clinic, January 1961. It was also given at the University of Kentucky Medical School Postgraduate course in Hematology, March 1961. Submitted for publication December 15, 1964.

\*Delatestryl® and Ora-Testryl® are Squibb trademarks.

mg./cc. in sesame oil or as an investigational double-strength formulation containing 400 mg./cc. in castor oil. In cases where injection therapy was resisted or poorly tolerated, either fluoxymesterone (Ora-Testryl®) or methandrostenolone (Dianabol†) was given in oral doses of 20 mg./day for three months. The patients continued to receive supportive care such as blood transfusions, corticosteroids, or vitamins, as indicated. In several instances, antileukemic therapy was continued concomitantly.

Complete blood counts were performed according to standard methods. Platelets and reticulocytes were counted by the indirect method, using brilliant cresyl blue. Supravital stains were used in performing peripheral blood and bone marrow differential counts. Bone marrow examinations were made in all patients prior to androgen therapy and, wherever feasible thereafter, were repeated as indicated.

### Results

An adequate trial of massive androgen therapy (that is, full dosage for at least three months) was completed in 45 of the 68 patients. Of these 45 patients, the treatment was associated with some degree of improvement in 20 cases (Table 2). Details

TABLE 2. *Clinical Results Achieved with Massive Androgen Therapy*

Diagnosis	No. of Cases	Excellent	Good	Fair	Failure
Hypoplastic anemia ....	16	4	1	0	11
Primary Myelofibrosis..	7	2	1	1	3
Chronic Lymphocytic leukemia .....	18	8	2	1	7
Achrestic anemia .....	4	0	0	0	4
TOTALS .....	45	14	4	2	25

of the responses in the patients with favorable results are recorded in Table 3.

#### *Hypoplastic Anemia*

Sixteen of the 33 patients with hypoplastic anemia received a full course of androgen therapy; this group consisted of six male, and 10 female patients, ranging in age from 1 to 82 years, with an average of 40 years. The duration of the disease from time of the diagnosis to onset of the androgen therapy varied from 2 to 20 months, averaging five months. In four patients, the hypoplasia was secondary to hair dye of undetermined composition, phenylbutazone, chloramphenicol, and cyclophosphamide, respectively; one patient suffered from congenital erythroid hypoplasia; and the remaining 11 cases were classified as idiopathic.

Two of the patients with idiopathic hypoplasia achieved *remissions* and possible cures. (See figures 1 and 6.) *Excellent* responses also were observed in two other cases, one with idiopathic anemia and one with hypoplasia secondary to cyclophosphamide. Both of these patients exhibited significant reticulocytosis. The second of these two patients also showed

a significant rise in neutrophils and platelets, and experienced stabilization of hemoglobin so that transfusions were obviated for more than three months. The patient with idiopathic hypoplasia, however, had no improvement in thrombocytopenia, and because of continued bleeding, transfusion requirements were not decreased. This patient ultimately succumbed to a massive intracerebral hemorrhage. One patient with anemia secondary to phenylbutazone had a *good* response in that the transfusion requirements were greatly reduced.

There were 11 patients who *failed* to respond to massive androgen therapy in this series of 16 cases. In addition, 17 patients with hypoplastic anemia, for diverse reasons, did not receive complete courses. Treatment was interrupted by death in 11 instances, and by local or general reactions, possibly attributable to the medication, in the remaining six cases. At the time this communication was prepared, 15 of these 17 patients had died.

The manifestations of androgenicity were prominent in these patients; a finding which correlated well with the fact that the age of these patients was relatively lower than that of the series as a whole. Acne, hirsutism, deepening of the voice, and increase in muscle mass were observed in nine of these younger patients. There were two cases with premature enlargement of the external genitalia, two with premature growth of axillary and pubic hair, and one with edema. There were no problems of androgenicity in the remaining patients.

#### *Primary Myelofibrosis*

The seven of the nine patients with primary myelofibrosis who completed the course of massive androgen therapy included four men and three women, ranging in age from 44 to 80 years with an average of 61 years. The duration of the disease, from the diagnosis to the beginning of treatment, was as much as 72 months in some cases; in others, therapy was initiated very soon after diagnosis.

The therapeutic results attained in two patients were rated as *excellent* as judged by the maintenance of suitable hemoglobin levels without transfusion during six to eight months of observation. (See fig. 5.) Another patient had a *good* response in that the transfusion requirements were eliminated for six months. One patient with a response rated as *fair* exhibited a significant reticulocytosis but no important alteration in transfusion requirements.

The remaining three patients evidenced *no response* or improvement under this treatment. One of the patients in whom treatment had been initiated succumbed to congestive heart failure. In another, the medication was discontinued because of nausea and pain at the injection site. Marked androgenicity was not a distressing problem in this group.

#### *Chronic Lymphocytic Leukemia*

Of the 21 patients with chronic lymphocytic leu-

\*Delatestryl® and Ora-Testryl® are Squibb trademarks.  
†Dianabol® is a Ciba trademark.



TABLE 3. Data on 20 Patients Responding Favorably to Androgens

Case No.	Disease Date	Age Sex	Andro- gen Date	Hgb. Rise Gm./ 100 ml	Retic. Rise %	Poly Rise Per cu. mm.	Platelet Rise	Transfusion Requirements Before During After Therapy	Bone Marrow Change Following Therapy Ery. Mye. Megakar.	Response	Duration of Response (months)
1	H.A.** 2-27-59	16 M	Dela- testryl 7-1-59	7.4- 14.6	5.0- 6.4	4,290- 6,156	36,000- 150,000	18 8 0	Incr. Nor. Incr.	Remission	Remission (cure?)
2	C.L.L.* 8-25-58	53 M	Dela- testryl 7-3-59	6.0- 14.6	0.0- 5.4	560- 5,168	0- 286,280	33 22 0	Nor. Nor. Incr.	Excellent	14+
4	C.L.L. 7-25-58	68 M	" 7-13-59	5.6- 10.0	0.2- 4.8	NONE	62,660- 386,560	11 5 0	Incr. ....	Good	6
9	C.L.L. 5-12-59	80 F	" 2-23-59	10.7- 12.2	1.4- 5.0	2,243- 4,538	Always normal	16 4 0		Excellent	6
13	C.L.L. 11-10-55	39 M	" 8-21-59	4.4- 13.5	0.2- 13.8	185- 3,650	0- 442,320	15 5 0	Incr. Incr. ....	Excellent	9
14	C.L.L. 8-4-57	46 M	" 8-23-59	4.2- 13.6	1.0- 13.6	NONE	21,000- 152,320	10 0 0	Nor. ....	Excellent	6
15	P.M.*** 2-10-59	73 M	" 8-27-59	8.8- 11.5	3.8- 10.8	NONE	Always high	7 2 0		Excellent	8
17	H.A. 7-19-59	4 M	" 9-23-59	5.1- 12.9	2.2- 10.0	460- 5,625	29,000- 500,000	2 3 0	Nor. Nor. Nor.	Remission	Remission (cure?)
19	C.L.L. 6-5-59	53 F	" 10-7-59	6.3- 14.0	0.8- 6.6	NONE	Always normal	0 8 0		Excellent	7+
23	H.A. 2-4-59	68 F	" 10-26-59	9.6- 11.6		NONE	Always normal	10 2 0		Good	9+
28	C.L.L. 9-17-56	70 M	Dela- testryl 12-4-59	5.0- 13.8	1.0- 9.4	742- 2,812	53,760- 720,000	24 0 0	.....	Excellent	10+
38	P.M. 1-11-60	69 F	" 1-13-60	Decr. 10.0 9.1	8.4- 19.4	NONE	Always high	8 0 0		Good	6
40	H.A. 7-5-58	40 F	Dianabol 2-1-60		1.5- 13.4	NONE	NONE	Slight decrease in requirement	Incr. Nor. ....	Good	.....
41	C.L.L. 10-9-59	42 M	Dela- testryl 2-16-60	10.9 15.4	5.0- 13.0	NONE	70,000- 398,000	9 0 0		Excellent	5+
53	C.L.L. 4-27-59	79 M	" 3-30-60	9.7- 11.8	2.0- 4.8	NONE	5,500- 483,460	0 0 0	Incr. Incr. ....	Excellent	5
54	P.M. 4-11-60	55 M	Dianabol 4-11-60	8.8- 12.4	6.4 Stable	NONE	Always normal	3 0 0		Excellent	6
56	H.A. 12-3-59	75 F	" 4-14-60	7.5- 11.8	1.8- 10.8	1,479- 4,392	130,000- 645,000	22 0 0		Excellent	6+
57	C.L.L. 1-2-59	63 M	" 4-26-60	6.8- 13.4	0.2- 10.0	NONE	7,880- 123,000	4 4 5	Incr. Incr. ....	Good	3
62	P.M. 5-18-60	50 M	" 5-18-60		0.4- 8.8	NONE	NONE	5 4 2		Fair	4
66	C.L.L. 7-16-57	38 M	Dela- testryl 6-8-60		2.8- 8.0	NONE	NONE	5 3 4		Fair	2

\* Chronic lymphatic leukemia

\*\* Hypoplastic anemia

\*\*\* Primary myelofibrosis

kemia, 18 (12 men and 6 women), ranging in age from 39 to 80 years (with an average of 61 years), completed the course of massive androgen therapy (Table 1). The time interval between the establishment of the diagnosis and the onset of bone marrow failure ranged from 4 to 72 months, with an average of 36 months.

Results rated as *excellent* were achieved in eight cases (Table 2 and Table 3). (See figures 2, 3, 4, and 7.) The need for transfusions was obviated in all eight patients for 5 to 18 months. In four patients, significant increases in neutrophil levels occurred, and in three there was a disappearance of thrombopenic bleeding associated with a significant increase in platelets. Repeated bone marrow examinations in four patients disclosed that the erythrocyte

precursors were restored to the normal levels in two cases and appreciably increased in the other two. In one patient, megakaryocytic regeneration was observed. The results in two patients were rated as *good* on the basis of significant reticulocytosis and stabilization of hemoglobin levels; the transfusion requirements were eliminated for three and for six months respectively. Both of these patients showed an increase in platelets, but neither had a rise in neutrophils. Repeated bone marrow examinations disclosed an increase in the levels of erythrocyte precursors in both patients and an increase in the level of granulocyte precursors in one case. One of these patients succumbed to overwhelming infection six months after the inception of massive androgen therapy. One patient had a significant reticulocyte re-

sponse, but experienced no change in transfusion requirements; his response, therefore, was rated as fair.

The seven remaining cases were considered as treatment failures. Three of the 21 patients in whom treatment had been initiated succumbed to cerebral hemorrhage before an adequate trial could be completed. Androgenic manifestations were minimal in this group, since most of the patients were elderly and the majority were men.

Achrestic Anemia

Four of the five patients with achrestic anemia received a full trial of massive androgen therapy. All were men, ranging in age from 57 to 81 years, with an average of 68 years. None of these patients had

a significant response to the hormone medication. Marked androgenicity was not manifested by any of them. One patient could not complete the full course of therapy because of nausea, malaise, and pain at the injection site.

Adverse Reactions

The reasons for the interruption of the androgen therapy before the course was completed in 23 out of the entire series of 68 patients are shown in Table 4. These reasons can be divided into two categories, death of the patient or intolerance to the therapy.

Death of Patient

Massive androgen therapy was interrupted by death in 15 cases, the usual causes being hemorrhage or in-

TABLE 4. Patients Not Completing a Full Course of Massive Androgen Therapy

GROUP A: Patients Dying Before Course Was Completed						
Case No.	Age	Color	Sex	Diagnosis	Androgen Used	Reason for Termination of Therapy
21	2	W	F	Hypoplastic anemia (secondary to sulfonamides)	Delatestryl (200 mg./ml.)	Death (septicemia)
22	49	W	F	Hypoplastic anemia	Delatestryl (200 mg./ml.)	Death (intracerebral hemorrhage)
32	32	W	F	Hypoplastic anemia (secondary to sulfonamides)	Delatestryl (200 mg./ml.)	Death (intracerebral hemorrhage)
42	3	W	F	Hypoplastic anemia (secondary to chloramphenicol)	Delatestryl (200 mg./ml.)	Death (meningitis)
43	60	W	M	Hypoplastic anemia (idiopathic)	Delatestryl (200 mg./ml.)	Death (massive gastrointestinal hemorrhage)
47	36	W	F	Hypoplastic anemia (secondary to streptomycin)	Ora-Testryl	Death (intracerebral hemorrhage)
50	11	W	M	Hypoplastic anemia (idiopathic)	Delatestryl (200 mg./ml.)	Death (intracerebral hemorrhage)
63	52	W	F	Hypoplastic anemia (secondary to chloramphenicol)	Delatestryl (400 mg./ml.)	Death (intracerebral hemorrhage)
51	11	W	F	Hodgkin's disease with cyclophosphamide induced marrow failure	Ora-Testryl	Death (respiratory failure)
52	25	W	F	Hodgkin's disease with cyclophosphamide induced marrow failure	Ora-Testryl	Death (hepatic failure)
60	41	W	M	Acute myeloid leukemia with drug-induced marrow failure	Dianabol	Death (intracerebral hemorrhage)
6	75	W	M	Myelofibrosis	Delatestryl (200 mg./ml.)	Death (heart failure)
31	54	W	M	Chronic lymphocytic leukemia	Delatestryl (200 mg./ml.)	Death (intracerebral hemorrhage)
55	59	W	F	Chronic lymphocytic leukemia	Delatestryl (200 mg./ml.)	Death (intracerebral hemorrhage)
64	66	W	M	Chronic lymphocytic leukemia	Delatestryl (400 mg./ml.)	Death (intracerebral hemorrhage)

GROUP B: Patients Discontinuing Therapy Before Course Was Completed						
59	53	W	F	Hypoplastic anemia (secondary to chloramphenicol)	Dianabol	Lingual edema, "heaviness all over"
11	58	W	F	Hypoplastic anemia (idiopathic)	Delatestryl (200 mg./ml.)	Pain at injection site
20	60	W	M	Hypoplastic anemia (idiopathic)	Delatestryl (200 mg./ml.)	Pain at injection site, generalized myalgia
54	55	W	M	Hypoplastic anemia	Dianabol	Cholestatic jaundice
74	58	W	F	Hypoplastic anemia	Dianabol	Cholestatic jaundice
35	60	W	M	Lymphosarcoma with cyclophosphamide induced marrow failure	Delatestryl (200 mg./ml.)	Unexplained jaundice
33	50	W	M	Myelofibrosis	Delatestryl (200 mg./ml.) Ora-Testryl	Pain at injection site, nausea
8	67	W	F	Achrestic anemia	Delatestryl (200 mg./ml.)	Pain at injection site, nausea, malaise



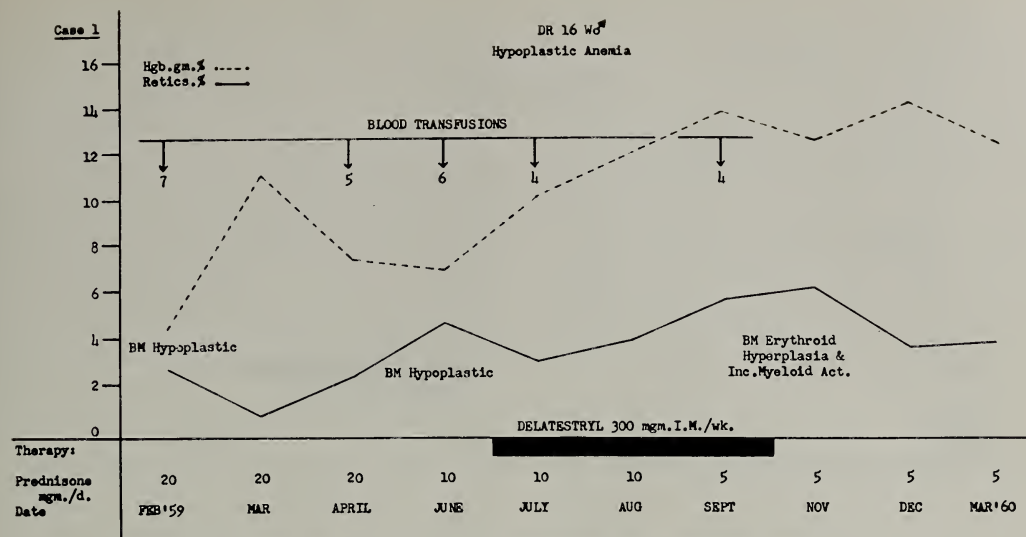


FIGURE 1. (Case 1)

fection. Hemorrhage accounted for 10 deaths (nine intracerebral, one gastrointestinal), and infection for two (one septicemia, one meningitis). Of the remaining three patients, one succumbed to heart failure, one to hepatic failure, and one to respiratory failure. All of these deaths were attributed to the disease, and in no instance was there evidence that massive androgen therapy was a significant contributory factor.

#### Intolerance to Medication

Adverse reactions of the patients to massive androgen therapy was responsible for the discontinuance of treatment in eight instances. Pain from injection

(four cases) and jaundice (four cases) were the principal forms of intolerance. Cholestatic jaundice occurred in 3 of the 12 patients who were given methandrosthenolone. One of the 51 patients given testosterone enanthate developed jaundice, the precise nature of which was not determined. However, this patient originally developed the marrow failure from the administration of cyclophosphamide, which may have had an adverse effect on hepatic function.

Testosterone enanthate was administered intramuscularly to 35 of the 45 patients who completed the therapeutic trial, eight received methandrosthenolone orally and two received fluoxymesterone orally. There were local reactions, of varying severity, as

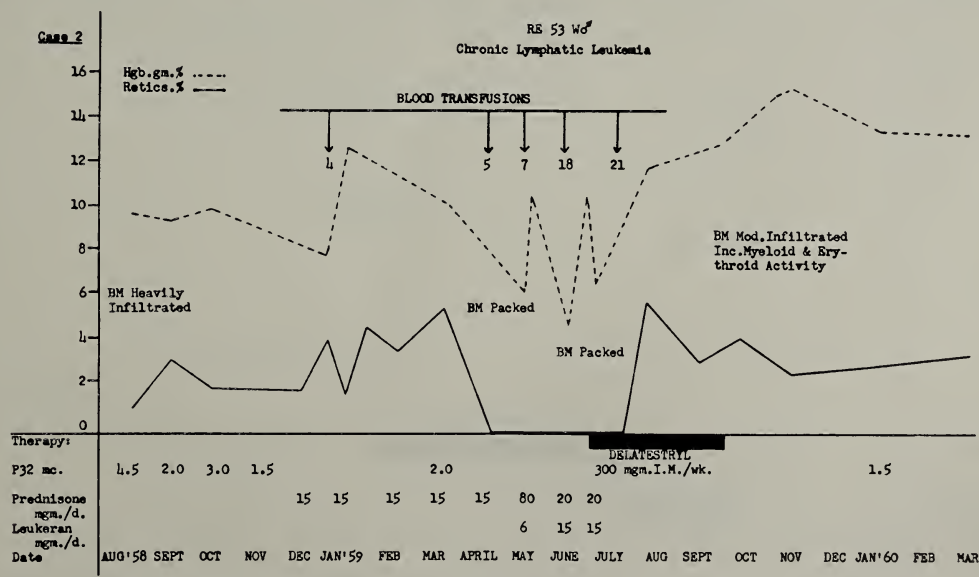


FIGURE 2. (Case 2)

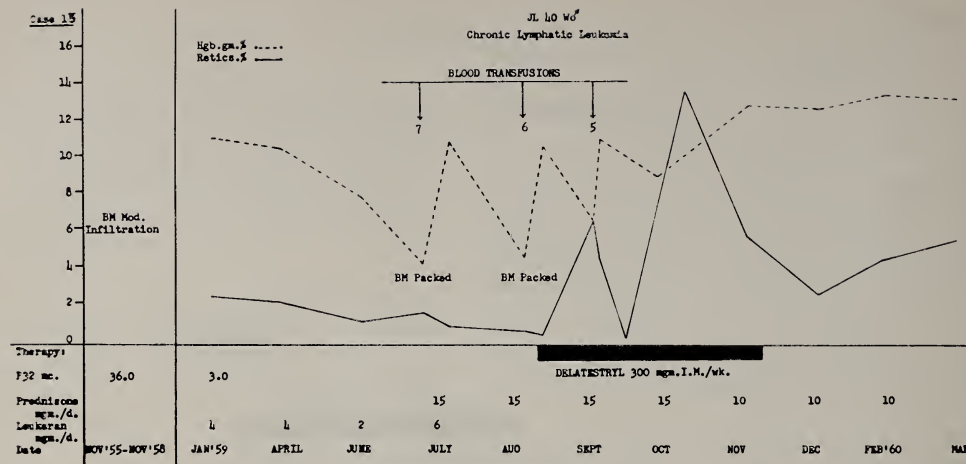


FIGURE 3 (Case 13)

well as a few mild systemic reactions to the commercially available formulation of testosterone enanthate in sesame oil (200 mg./ml.). On the other hand, there were no local reactions to the double-strength preparation (400 mg./ml.) in castor oil. It is suspected that intolerance for sesame oil explains the local and systemic reactions to the lower concentration preparation.

### Discussion

The favorable response of anemia associated with androgen deficiency when specific substitution is provided suggests that a physiologic level of androgen

is essential for normal erythropoiesis. This type of anemia is thus analogous to those associated with hypothyroidism or with adrenal insufficiency in that specific correction of the deficiency is required to reverse the anemia. The precise role of these endocrine factors in hematopoiesis is not known.

A completely different principle of treatment is involved in the use of pharmacologic doses of androgens in the management of nonendocrine anemic states. Failure to make this distinction in dosage apparently accounts for the limited success in the earlier investigations of Rosenthal and Erf<sup>8</sup> and Herbut,<sup>9</sup> in which conventional doses of androgen

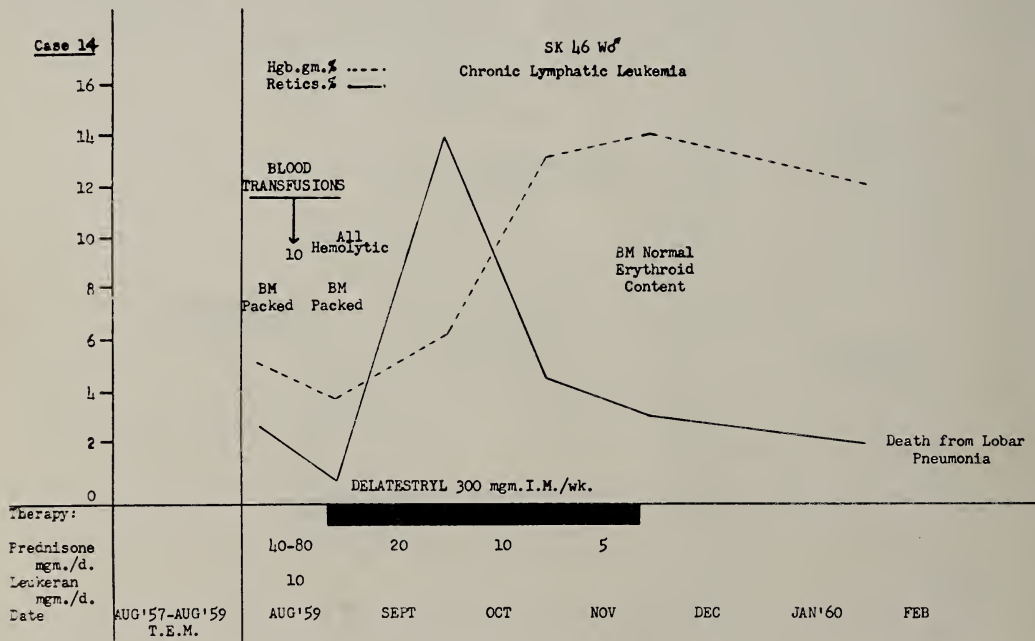


FIGURE 4. (Case 14)



were used to treat myelofibrosis. Whether the use of large doses of androgens results in a simple magnification of its hematopoietic activity or whether this invokes an entirely distinct action as yet has not been determined.

It is obvious from this communication and from the previous reports that the degree of success in the treatment of these blood dyscrasias with massive androgen therapy varies considerably. In the present study, striking responses were noted in some instances of hypoplastic anemia, primary myelofibrosis, and chronic lymphocytic leukemia. Maximal responses in these conditions were characterized primarily by gradual rise in hemoglobin and erythrocyte levels associated with delayed but lasting reticulocytosis and erythroid hyperplasia of the bone marrow. In several instances, neutrophil and, to a less extent, even platelet levels also increased in association with hyperplastic activity of corresponding elements.

As might be expected, the maximal responses vary with the nature of the disease. Thus, with acquired hypoplastic anemia, apparently complete remissions have been achieved that are not dependent upon maintenance therapy. Favorable results have been observed in constitutional hypoplastic anemia, but the basic defect presumably is not permanently influenced, since improvement cannot be sustained without maintenance therapy. Androgens have induced a favorable response in the bone marrow failure of myelofibrosis and of chronic lymphocytic leukemia, but in these conditions, the hormonal agents must be classified as palliative rather than as potentially curative medications.

Responses short of maximal have, from a practical standpoint, permitted reduction of transfusion requirements to a greater or lesser degree. Occasional instances in which reticulocytosis is unaccompanied by significant improvement in the blood count may be regarded technically as positive hematologic responses, but there is no therapeutic response in a practical sense.

The favorable results in patients with hypoplastic anemia and with primary myelofibrosis were comparable to those previously reported. The proportion of maximal responses was less, however, than that indicated in the earlier series. Intolerance to the medication accounted for significant interference with successful therapy.

This communication presents a predominance of experience and favorable results in patients with bone marrow failure complicating chronic lymphocytic leukemia. Thus 11 of the 20 patients with favorable responses to androgen therapy in the present series had lymphocytic leukemia, while only seven patients with the same condition had no improvement. The complication of bone marrow failure was foreshadowed by the appearance in these patients of refractoriness to conventional suppressive agents such as radiophosphorus, x-irradiation, and alkylating agents, the continued use of which merely hastened hematopoietic decompensation. This refractory state was rapidly complicated by heavy lymphocytic infiltration of the marrow and consequent failure of hematopoiesis. All of the patients in this series developed bone marrow failure within 72 months after the diagnosis of chronic lymphocytic leukemia was

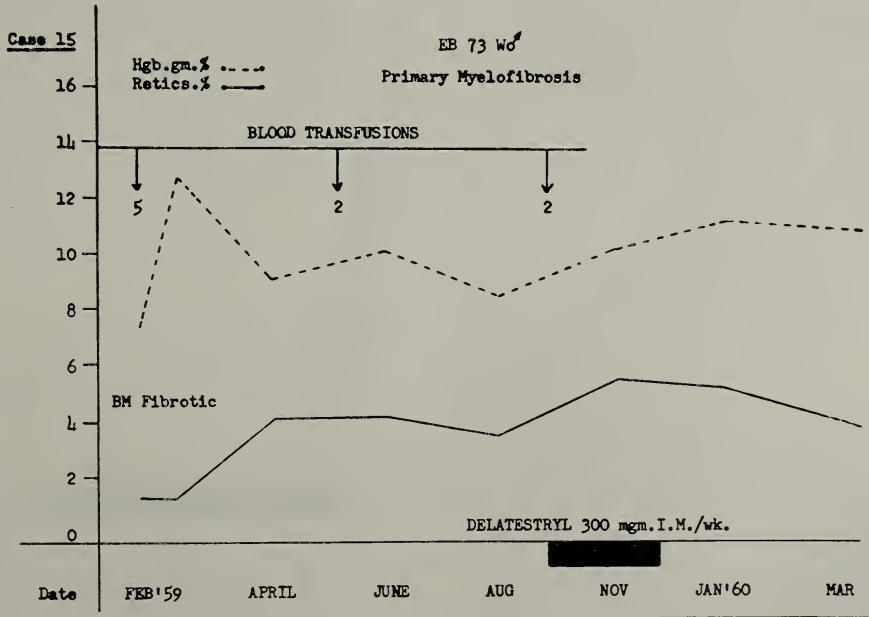


FIGURE 5. (Case 15)

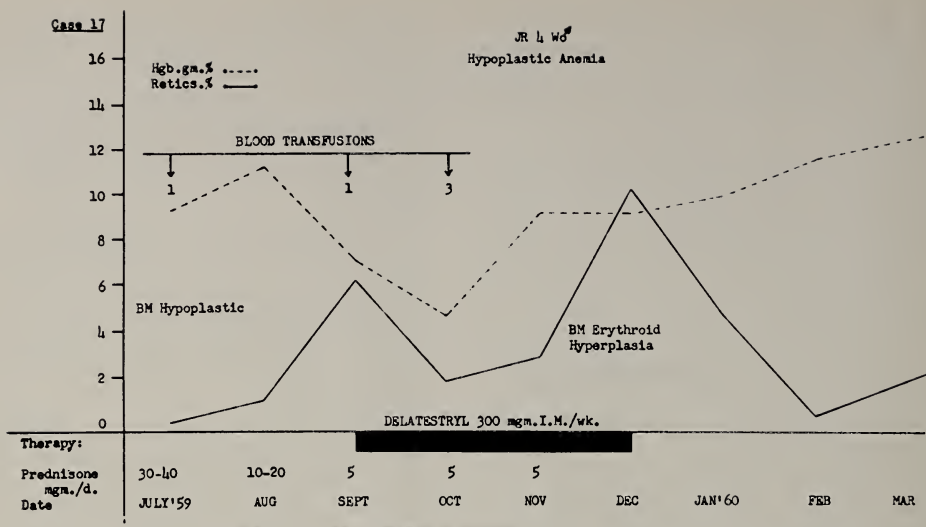


FIGURE 6. (Case 17)

first made, and in a majority of instances the complication appeared within 36 months.

Bone marrow failure was characterized by the following striking findings: a rapidly developing anemia of dimorphic type, myelophthistic and hemolytic, associated with reticulopenia and necessitating frequent transfusions; marked impaction of the bone marrow, which became difficult to aspirate; neutropenia and thrombocytopenia associated with susceptibility to infection and bleeding tendency; and asthenia and other manifestations or complications of anemia, such

as cardiac failure. Susceptibility to transfusion reactions, sometimes attributable to demonstrable leukagglutinins, and at other times of obscure pathogenesis, was also observed in some of the patients in the present series who had lymphocytic leukemia.

Effective androgen appeared not only to stimulate production of normal marrow elements but to induce lympholysis as well. Lymphocyte destruction was achieved independently of administration of radiation or chemical agents.

The lympholytic activity of androgens has been

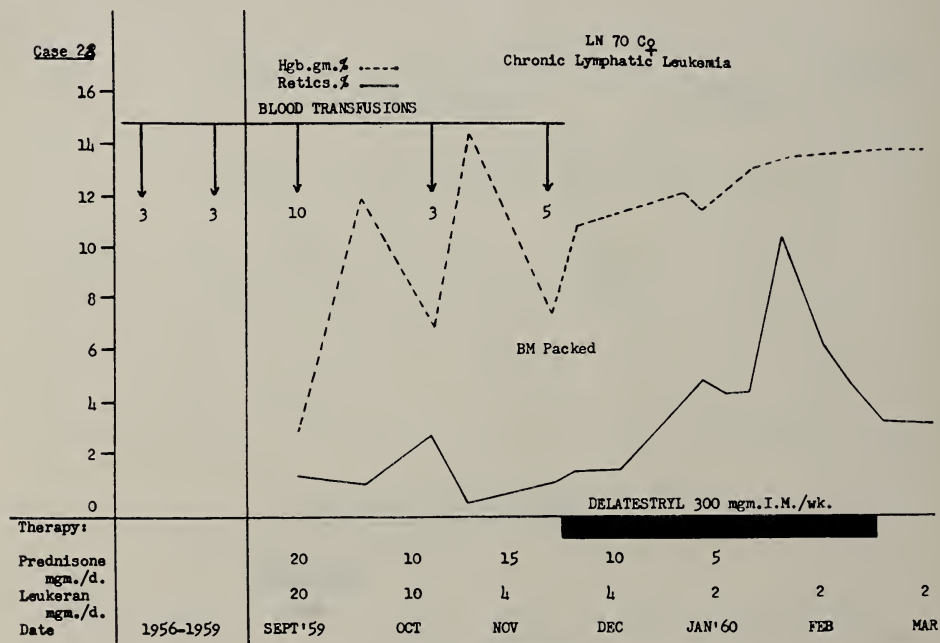


FIGURE 7. (Case 28)



suggested in the past by a number of investigations in animals; thus, in animal experiments, testosterone has been reported to exhibit the following effects<sup>16</sup>: (1) decrease in thymus weights in rats; (2) inhibition of lymphoid tumor development in mice treated concurrently with estrogen; (3) inhibition of thymic regeneration after x-irradiation; (4) decreased incidence of leukemia in spayed mice bearing testosterone pellets as compared with spayed or intact female controls; (5) reduced lymphoid tumor incidence in irradiated female mice; and (6) inhibition of irradiation-induced lymphomas in adult male black mice. This activity also has been mentioned by Gardner and Pringle<sup>3</sup> in their discussion of androgens in the treatment of lymphomatous diseases.

The demonstrated effectiveness of androgens in chronic lymphocytic leukemia suggests that these hormones might be related, in some way, to the factor reported by Miller,<sup>17</sup> who postulated the control of leukopoiesis on the basis of complemental hormonal substances, one granulocyte-stimulating and lymphocyte-maturing (lympholytic), the other with a reciprocal activity. Both androgens and corticosteroids appear to share, to some extent, the properties of the former hypothetical substance that Miller chose to call myelokentric acid. No endocrine factor can as yet be linked with this hypothetical substance.

Little need be said about the use of androgens for the treatment of achrestic anemia except that there was no evident response. Similar ineffectiveness, in a single case, was reported by Watkinson and his co-workers.<sup>4</sup> It may be suspected that this disorder (or category of disorders) probably stems from a deficiency that cannot be bypassed by the administration of androgens in pharmacologic doses.

### Summary

1. From July 1, 1959 through June 30, 1960, massive-dose androgen therapy was administered to 68 patients with bone marrow failure associated with chronic lymphocytic leukemia (21 cases), hypoplastic anemia (33 cases), primary myelofibrosis (nine cases), and achrestic anemia (five cases). Fifty-one patients received testosterone enanthate, 12 received methandostenolone and five had fluoxymesterone therapy.

2. Forty-five of the 68 patients completed a 3-month course of massive androgen therapy. Treatment was interrupted by death in 15 cases and by drug intolerance in eight others (local irritation in four, jaundice in four) before adequate trials were completed.

3. Of the 45 patients who received an adequate trial: 18 had chronic lymphocytic leukemia, 11 of whom showed favorable responses and seven in whom the treatment was unsuccessful; 16 had hypoplastic anemia, five responding well (including two remissions) and 11 with treatment failures; seven with primary myelofibrosis, four responding well and three

experiencing failure; and four patients with achrestic anemia, all of whom failed to improve with massive androgen therapy.

4. Massive androgen therapy appears to stimulate erythropoiesis predominantly, but in some instances granulopoiesis and thrombopoiesis as well. In chronic lymphocytic leukemia, there may be concomitant lympholytic activity.

5. The mechanism of the hematopoietic action of pharmacologic doses of androgens is not known, nor is there any available explanation for the success of therapy in some instances and failure in others.

### Addendum

The medications of which mention is made in the present communication are: testosterone (Androlin®, Andronaq®, Andrusol®, Malestrone®, Testrone®, Testryl®, Mertestate®, Neo-Hombreol®, Oreton®, Testandron®, Testosteroid®), testosterone enanthate (Delatesteryl®), fluoxymesterone (Ora-Testryl®), methandrosteranolone (Dianabol®) phenylbutazone (Butazolidin®), chloramphenicol (Chloromycetin®) and cyclophosphamide (Cytosan®). Chlorambucil (Leukeran®), triethylenemelamine (Tem®).

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# Survival of Skin Homografts

## A Study of the Effects of Saline Extracts Of Homologous Skin in Rabbits

WALTER E. GEORGE, B.S., and ROGER D. WILLIAMS, M.D.

THE results of several investigators in an attempt to prolong homograft survival have been inconsistent. Bonfiglio and others<sup>1</sup> reported that saline buffered extract of ground rabbit skin, which has all subcutaneous tissue and blood vessels removed, produced a slightly increased survival of skin homografts in rabbits. Teraski<sup>2</sup> states that in chickens tolerance of skin homografts could not be induced with self free extracts of known antigenic potency. Hardin<sup>3</sup> reported that the subcutaneous injections of homologous skin extracts given before, after, or on the day of transplantation resulted in permanent viability in the majority of skin homografts in CFW mice. The present study was undertaken to re-evaluate the effect of saline extracts of homologous skin which Allen et al.<sup>4</sup> reported had an enhancing effect on skin homografts in rabbits.

### Methods

Twenty-one male rabbits, weighing from 4 to 6 pounds were used in this study. The homograft and autograft, or only a homograft was sutured to the back of each rabbit. All grafts measured 16 sq. cm., were full thickness skin without panniculus carnosus and were transferred under aseptic conditions between nonrelated rabbits.

The preparation of the extract, protocol of extract injection, method of grafting and criteria for survival were the same as those employed by Allen and Associates.<sup>4</sup>

Table 1 outlines the groups and protocol of the skin grafting procedure.

### Results

Both a homograft and an autograft were transferred to 12 rabbits; of these animals two grafts were cut from the back of each, one immediately behind the other. The inferior graft was then sutured into the superior graft bed and served as the autograft; the inferior graft bed was then occupied by a graft from a nonrelated animal and served as a homograft.

<sup>1</sup>From the Department of Surgery, The Ohio State University Hospitals, Columbus, Ohio. Submitted August 20, 1964.

This study was supported by the University Office of Research, The Ohio State University.

### The Authors

● Mr. George, Columbus, is Third Year Medical Student, The Ohio State University College of Medicine.

● Dr. Williams, Columbus, is a member of the Attending Staff, University Hospital; Professor of Surgery, The Ohio State University College of Medicine.

Two of these 12 animals composed the control group, each serving as the source of the homograft for the other. Their average homograft rejection time was 10 days (10 to 11 days). One of these 12 rabbits received injections of saline extract of rabbit skin different from the donor or itself. Its rejection time was nine days. Four of these 12 animals each received a graft from an animal that had been injected with the saline extract of skin different from the host or itself. Their average homograft rejection time was nine days (8 to 9 days).

Nine rabbits received only the homograft. One graft was cut from the back of each and the grafts were transferred between nonrelated rabbits. One of these nine animals served as a control. Its homograft was received from a nonrelated rabbit. The rejection time for this control was eight days. Four of these nine rabbits each received injections of saline extract of donor skin. Their average homograft rejection time was eight days (7 to 9 days). The remaining four rabbits each received a graft from a rabbit that had received injections of saline extract of skin from the host rabbit. Their average homograft rejection time was eight days.

### Discussion

The increased survival time of one day for the control homograft with accompanying autografts over the control rabbits without an accompanying autograft is not significant with this small study. It might be due to nonspecific stress factors resulting from the increased surgical trauma in those animals with autografts as well as homografts. All of the



autografts except one were viable at the end of the experiment. This indicates that homograft rejection is altered from causes other than surgical technique. This study does not support the conclusions of Zotikov and associates<sup>6</sup> that the presence of an autograft significantly prolongs the survival time of an accompanying homograft.

From an analysis of Table 1 it is seen that the host injection with donor extract, nonspecific homol-

TABLE 1. *Effect of Extract Injection on Homograft Survival*

Group	Number	Average Rejection Time	Range of Rejection Time
Control	3	9 days	8-10 days
Host injection with donor extract	5	10 days	10-11 days
Host injection with nonspecific homologous extract**	1	9 days	9 days
Donor injection with nonspecific homologous extract	4	9 days	8-9 days
Host injection with donor extract (no autograft)	4	8 days	7-9 days
Donor injection with host extract (no autograft)	5	8 days	8 days

\*\* Nonspecific homologous extract refers to a skin extract from a rabbit other than the ultimate skin donor or host rabbit.

ogous extract, donor injection with host extract, or nonspecific homologous extract, does not significantly alter homograft survival time regardless of the presence of an autograft. Medawar<sup>5</sup> was unable to substantiate the conclusions of Allen et al.; however, Medawar made several changes in the experimental design. Probably one of the more significant of these modifications was the omitting of the control autograft in each of the animals. Although Zotikov and associates<sup>6</sup> have since reported that the presence of an autograft prolongs the survival of the accompanying homograft, we have not been able to substantiate their results.

The group directly comparable with Allen and associates' animals was the group where the most animals were injected with donor extract and received

both a homograft and an autograft. Allen et al.<sup>4</sup> reported an average survival time of 23 days for the homograft in this group compared to an average survival time of seven days for the homografts in his control group. This is better than a threefold increase in survival time. The present study reports only a one day difference between those with skin extract, autograft and homograft and the controls. The contention of Medawar<sup>5</sup> that there might have been a close genetic relationship between donor and recipient animals, remains the most likely explanation for these earlier reported results.

## Summary

A study of skin homotransplantation in unrelated adult rabbits showed that:

1. The presence of an autograft does not significantly prolong the survival time of an accompanying skin homograft.
2. Host injection of saline extracts of donor skin do not significantly alter skin homograft survival time.
3. Host injection with a saline extract of homologous skin, the source of which is not the host or donor animal, do not significantly alter the homograft survival time.
4. Donor injections of the saline extract of host skin do not alter significantly the homograft survival time.
5. Donor injections of saline extract of homologous skin, the first of which is not the host or donor rabbit, do not alter significantly the homograft survival.

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**INJECTION GRANULOMA.**—A report is made of a rapidly growing acid-fast bacillus identified as *Mycobacterium fortuitum* cultured from chronic granulomas in man that occurred weeks to months following the injection of influenza vaccine in most cases and other parenteral medications in a few. In guinea pigs the *Mycobacterium* isolated failed to produce generalized disease but did produce local subcutaneous granulomas. It is suggested that all lesions related to the site of a previous hypodermic injection be carefully examined by microbiologic technics including those for demonstration of acid-fast microorganisms and, if necessary, by animal inoculation so specific and adequate therapy may be instituted by the attending physician.—May Owen, M. D., Alice Smith, M. D., and John Coultras, B. A., M. S., Fort Worth, Texas, *Southern Medical Journal*, 56:949-952, (Sept.) 1963.

# Chiari-Frommel Syndrome

## Report of a Case

NEJDAT P. MULLA, M.D.

THE Chiari-Frommel syndrome may be defined as a complex of endocrinological symptoms consisting of postpartum galactorrhea and amenorrhea as well as atrophy of the uterus and ovaries. Since the clinical picture was described, in 1855, by Chiari and, in 1882, by Frommel, 22 cases have been reported in the literature.<sup>1-3</sup> Recovery followed by pregnancy was observed in five instances.<sup>1,3-5</sup>

In the accounts to date, the syndrome has occurred in only primigravida patients between the ages of 17 and 35 years with a duration of symptoms from one to eight years. Persistent galactorrhea appeared to have no relationship to breast feeding. The breasts remained full, with either continuous lactation or easily expressible milk, in all women. While the fluid presented the appearance of normal breast milk, chemical and microscopic characteristics were intermediate between those of colostrum and normal milk.

The amenorrhea generally occurred after an anovulatory menstrual period. This was followed by various degrees of atrophy of the uterus as well as, in some cases, the vulva and vagina. Navicular cells were observed in the vaginal smear, while biopsy showed endometrial atrophy. The morning temperature curve was monophasic and the fern test negative. Urinary elimination of gonadotropin and estrogen was reduced. However, excretion of 17-ketosteroids was normal. Serum protein bound iodine and basal metabolic rate were not remarkable. Further examinations, including ophthalmological and x-ray of the sella tursica, yielded negative results. Body weight increased.

A similar syndrome not associated with pregnancy and attributed to pituitary and/or intracranial tumor was described by Argonz and Del Castillo, in 1933.<sup>6</sup> One year later Forbes et al.<sup>7</sup> reported 15 cases, followed since by further reports. Galactorrhea has been observed after thoracotomy and pneumonectomy,<sup>8</sup> probably due to stimulation of the peripheral nerves which control the sucking reflex. Sachs observed lactation following hysterectomy and partial oophorectomy.<sup>9</sup> Drugs capable of affecting the hypothalamus promote galactorrhea.<sup>10,11</sup>

A case in which the symptoms coincide with those

### *The Author*

● Dr. Mulla, Kent, Ohio, is a member of the staffs of Robinson Memorial Hospital, Ravenna, and St. Thomas Hospital, Akron.

of the Chiari-Frommel syndrome was recently observed. The patient subsequently became pregnant and was delivered of a living infant.

### *Case Report*

A 25 year old white woman, gravida I, Para I, was seen on April 12, 1961, giving a history of secondary amenorrhea of three years' duration and stating a desire to have another child. Past history stated a beginning menarche at the age of 11 years, followed by a regular menstrual cycle. Soon after marriage, at the age of 20 years, the patient became pregnant. The last menstrual period was said to have occurred on December 27, 1956. On November 11, 1957, she was delivered of a 7½ lb. male infant. The labor, delivery, and postpartum course were uneventful. Diethylstilbesterol was administered to terminate lactation. However, lactation continued and the menstrual cycle failed to commence. Between 1957 and 1961, the patient was treated by various physicians with high dosages of estrogen and progesterone without success. In the interim, she had gained 40 pounds.

Physical examination revealed an obese, white woman appearing older than her age, 64 inches tall and weighing 162 lbs. Body hair was evenly distributed. The breasts were enlarged and a milky fluid was expressible from both nipples. Heart and lung examination revealed no abnormalities. Blood pressure was 130/76. Ophthalmological examination indicated the field of vision and fundi to be normal. Results of neurological tests were negative. A skull x-ray visualized a normal sella tursica and petrous and sphenoid ridges.

Upon pelvic examination, the external genitalia and pubic hair distribution as well as the vagina appeared to be normal. The cervix was small and mucous plug was absent. The uterus was small and freely movable. The adnexae were not palpable. A vaginal smear showed navicular cells of the secondary amenorrhea type. Basal body temperature was monophasic.

The results of laboratory examinations were as follows: The urine specific gravity was 1.016 with a trace of sugar and no albumin. Complete blood count was within normal limits with a hemoglobin of 13.5 Gm. Fasting blood sugar was 86 mg./100 ml. Serum protein bound iodine was 6.6 micrograms per 100 ml. The 17-ketosteroid excretion was 11.9 mg. per 24 hours.

On April 20, 1961, the patient was admitted to Robinson Memorial Hospital in Ravenna, Ohio. The following morning, a dilatation and curettage followed by laparotomy was performed. The uterine cavity measured 2 inches in depth. The endometrium was atrophic. Upon laparotomy the ovaries were very small and were hard and atrophic in





FIG. 1. Microscopic sections of the Chiari-Frommel syndrome ovary visualizing the polycystic appearance.

appearance. A wedge section was taken from each ovary. Microscopic examinations of the sections showed a fibrotic thickening of the cortex with numerous follicular cysts. (See Fig. 1.)

The following medications were immediately begun: Cytomel®, 25 mcg. daily; Celestone® tablets, 1 daily; Diamox®, 0.5 Gm. daily; and Elavil®, 10 mg. three times a day. Four months later, on August 21, 1961, the first menstrual period since 1957 began and lasted three days. Menstruation then occurred every 40 days, gradually returning to the 28-30 day cycle. The basal body temperature returned to its normal variation. In April, 1962, medication was discontinued because of return to normal function.

On June 5, 1962, the patient visited the office, reporting the absence of menstruation during the month of May. A bimanual examination indicated a soft, enlarged uterus. A pregnancy test was reported to be positive. Duphaston® was administered during the entire first trimester. On January 3, 1963, the patient was delivered of a normal female infant. Labor and delivery were uneventful and the postpartum course normal. The menstrual cycle returned to normal eight weeks following delivery.

### Comment

Any consideration of abnormal lactation is complex and cannot be studied with exactness because the physiology of lactogenesis and lactopoiesis is not completely understood. It has been established that the anterior pituitary gland secretes a hormone with lactogenic properties,<sup>12</sup> prolactin, which is produced by the eosinophilic cells.<sup>13</sup> Eckles et al.<sup>14</sup> suggest that neurohumeral impulses originate from the hypothalamus and probably have a constant inhibitory effect on the production of prolactin.

Hypothalamic control of the chain of events, by way of the pituitary, leading to ovarian function is directly influenced by neural pathways. These carry stimuli from the amygdaloid and other autonomic centers. There is also active a hormonal feed-back mechanism which stimulates hypothalamic and hormonal output when the circulating level of gonadal steroid drops and suppresses these functions when the steroid levels rise. This is exemplified when polycystic ovaries are treated by wedge resection. The resulting drop in follicle estrogen creates sufficient

rebound effect to reestablish ovulatory cycles and normal balance in the neurohumeral system.

Since a fibrotic capsule with multiple atretic follicular cysts are seen not only in normal ovaries but also in Stein-Leventhal syndrome, Chiari-Frommel syndrome, and other gynecological disorders, the central nervous system and neurohumeral mechanism require further study in order to explain the etiology of these ovarian dysfunctions.

### Summary

1. A case of Chiari-Frommel syndrome has been reported.
2. Twenty-two cases have been reported in the literature. Pregnancy followed in five instances.
3. The endocrinological considerations pertinent to lactation and amenorrhea have been discussed.

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# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT G. THOMAS, M. D., *President*

## PRESENTATION OF CASE

A WHITE man, aged 39 years, entered University Hospital complaining primarily of a tight pain in his chest on exertion and promptly relieved with rest. At age 19 he had rheumatic fever and had been rejected for military service because of "something wrong with his heart." Two years prior to admission he fainted after suffering pain in his anterior chest. He was kept in a local hospital for eight days and was told he had had a heart attack. Four months before his admission to University Hospital he developed a squeezing chest pain, severe exertional dyspnea, paroxysmal nocturnal dyspnea, and 5-pillow orthopnea. He was treated with digitalis, diuretics, Peritrate®, and phenobarbital.

Physical examination revealed a slender white man in no acute distress. The blood pressure was 80/60 in both arms, pulse rate 90 per minute, and respiratory rate 18 per minute. All peripheral pulses were present but diminished. Fine basilar râles were heard in the chest. The heart was 1 to 2 cm. enlarged to the left of the midclavicular line. It had a prominent left ventricular heave, regular rhythm, a Grade IV/VI aortic systolic coarse ejection murmur that radiated to the neck and over the entire precordium, and a Grade II/VI early diastolic blow at the left sternal border and in the aortic area. There was no peripheral edema. The fingertips showed some clubbing but no cyanosis.

The blood count, urine, fasting blood sugar, electrolytes, and CO<sub>2</sub> combining power were normal. The blood urea nitrogen was 24 mg. per 100 ml., the creatinine normal. The electrocardiogram showed notched P waves, complete left bundle branch block, marked left ventricular enlargement, and premature ventricular contractions. Chest film and cardiac fluoroscopy showed calcification within the aortic valve, a slightly enlarged heart with elongated apical shadow, and enlargement of the left atrium and ventricle. The following data were obtained from a trans-septal left atrial puncture: left atrial mean pres-

## Presented by

- Howard D. Sirak, M. D., Columbus, and
- Emmerich von Haam, M. D., Columbus;
- Joseph M. Ryan, M. D., *Moderator.*

Edited by Dr. von Haam.

sure 24, A-V gradient 0; pressure in left ventricle 191/37; in aorta 85/50; in brachial artery 90/54 (mean 67); V-A gradient 106 (peaked gradient); right ventricular pressure 54/5; pulmonary artery pressure 50/24 with a mean of 34.

The patient was discharged to continue on digoxin and Diuril® therapy and to be readmitted one week later for retrograde femoral aortogram. This was interpreted as showing a high degree of aortic regurgitation and evidence suggestive of aortic stenosis. The left coronary artery was large, the right coronary artery smaller than normal.

He was readmitted for surgery one month later, when his symptoms were predominantly shortness of breath and dyspnea. At surgery five days later his aortic valve was replaced with a Starr-Edward prosthesis, with no operative complications. At surgery it was noted that the patient's blood did not clot well. His immediate postoperative course was satisfactory. For the first six postoperative days his rectal temperature ranged between 100 and 103°F.; after the seventh postoperative day he was afebrile. On the fourth postoperative day treatment with Coumadin® was started. Blood transfusions were necessary for several days after surgery.

About a week after surgery rather large amounts of reddish thick material were draining from the sternal wound. The wound was reopened and the tissues were found to be separated down to the sternum; however, the heavy wire sutures around the sternum were intact. Culture of the wound drainage grew coagulase positive Staphylococci. The two blood cultures taken showed no growth. The patient was

Submitted January 21, 1965.



treated with large doses of penicillin and streptomycin. He gradually improved and was discharged on the 29th postoperative day on erythromycin, Pen Vee K®, digoxin, and Coumadin.

Six weeks after discharge the patient reported gradually increasing strength and decreased orthopnea, no paroxysmal nocturnal dyspnea or syncopal attacks. The chest wound was still draining slightly. The cardiologist thought he was doing well. His medications were continued and he made satisfactory improvement until five months after surgery when he complained of ankle edema for two weeks and had a hemoglobin of 8 Gm. Immediate readmission was arranged.

When questioned in the hospital he complained of fatigue for four to six weeks. One week prior to admission he noted red spots on both lower extremities, chills and fever, and during the ensuing week he developed increasing dyspnea on exertion, and paroxysmal nocturnal dyspnea which he had not had since surgery. His blood pressure was 102/40, his temperature 100.2°F., pulse rate 86 per minute and regular, and respirations 25. There was minimal venous distention in the neck. Bilateral basilar râles were heard, more prominent on the right.

The point of maximal impulse of the heart was 1 cm. medial to the left anterior axillary line in the sixth interspace. Auscultation revealed a Grade V/VI apical holosystolic regurgitant murmur which radiated through the precordium into the left axilla; a Grade V/VI ejection systolic murmur over the right second interspace which radiated toward the apex; a Grade III/VI high-pitched blowing diastolic murmur along the left sternal border, most intense at the third left intercostal space; and a very prominent opening snap. The aortic valve opening and closing sounds were not as sharp nor as distinct as had been heard with similar valves. The liver was palpable 2 fingerbreadths below the right costal margin. There were petechiae on both pretibial and pedal areas and splinter hemorrhages in the nail beds of both hands.

The hemoglobin was 7.9 Gm., hematocrit 25 per cent, the white blood cell count 10,400 with 77 per cent neutrophils; the reticulocyte count was 3.3 per cent; prothrombin time was 70.4 per cent. The serum electrolytes were normal except for a potassium of 3.7 mEq./L. The serum iron was 16 mcg. and the iron-binding capacity 323 mcg. per 100 ml. The blood urea nitrogen was 39 mg. Blood cultures on admission grew coagulase negative Staphylococci sensitive to penicillin.

The patient received 40 million units of penicillin intravenously daily and remained afebrile for 45 days. An abscess of the sternum was incised and drained on three occasions. He had persistent tachycardia and anemia and developed microscopic hematuria. On the 46th hospital day the patient suddenly spiked a fever to 102° and at this time his diastolic pressure dropped to almost zero. The chest films demon-

strated double exposure of the Starr-Edward prosthesis and showed it to move in an arc of almost 180°. His fever persisted and large doses of Staphicillin® and streptomycin were started but for the last three days of his life his temperature remained between 103 and 105°. He became progressively more short of breath and died on the 49th day.

#### CLINICAL DISCUSSION

DR. RYAN: We have an interesting pathology conference case, I think not so much from a diagnostic point of view as from the management points of view that have become increasingly complex and vexing to those of us involved in this area. Dr. Sirak.

DR. SIRAK: I am not going to go into all details of this history but I merely want to stress some of the important points. I think one of the first things that strikes me is the squeezing chest pain, and I think that chest pain is more common in a patient with aortic stenosis than with aortic insufficiency. The exertional dyspnea, the paroxysmal nocturnal dyspnea and orthopnea are signals of early heart failure. At the age of 19 he had rheumatic fever and was rejected for military service. His physical examination is not particularly remarkable from a differential point of view except that this was an individual who was obviously in heart failure and whose blood pressure might very well have been low. I think what is significant here is that the patient had an aortic systolic murmur, and I assume that this listener heard the diastolic murmur at the same time. The aortic systolic murmur was a harsher murmur than the diastolic murmur, and I think you would expect this. I think very often you see an individual who has primarily aortic stenosis but who also has a little insufficiency. The valves are frozen and have no real functional capability and you are bound to have some blood leaking backward.

#### No Mitral Lesion

There is one thing that is significant by omission and that is that no mention is made here of any mitral lesion. This is why I want to come back to this diagnosis of a rheumatic aortic stenosis. From the information we are now getting in the operating room, we find that our concept of rheumatic fever as the cause of pure aortic stenosis is incorrect. When you have a patient who has a pure aortic stenosis, at no matter what age, it is most likely a congenital valve which has become calcified, stiffened, and functionally abnormal. The patient of course does not have any problem until later in life. A congenital bicuspid valve can function perfectly satisfactorily early in life, giving the patient no trouble whatsoever, and yet as this patient gets into the fourth and fifth decades this bicuspid valve is not able to stand up under the duress of the two billion cardiac cycles through which it must go in a man 70 years old or more, and it begins to thicken and

calcify. It is then that this valvular lesion becomes physiologically significant.

### Pure Aortic Stenosis, Probably Not Rheumatic

If the patient has aortic stenosis and mitral stenosis, then you can make your diagnosis of rheumatic fever whether or not you get a history of joint pains. But I think in the presence of a pure aortic valvular lesion a rheumatic etiology is improbable. My proof of this is the direct inspection of these valves in the operating room. I have now operated on a number of them that were diagnosed as pure aortic stenosis of rheumatic etiology, many of them with an acceptable story of rheumatic fever, and yet in the operating room one finds that this is a congenital bicuspid valve that has become calcified. You can tell the difference between a bicuspid valve which has become calcified and has never had a significant commissure and a valve with a commissure obliterated by calcification and disease. Let's look at the x-rays.

DR. DUNBAR: The first film was taken five days before the aortic valve prosthesis. The heart is moderately enlarged, mainly left ventricular. There is also evidence of left atrial enlargement, and there is definite severe passive pulmonary congestion. A diagnosis of aortic valvular disease was made, and I can't see any real clues about the mitral valve. This left atrial enlargement does not prove mitral valve disease in the face of a significant aortic valve stenosis or insufficiency. An aortogram showed a severe aortic insufficiency. The valve appears to be three-cusped; however, I don't feel that this is reliable in that a large bicuspid valve, particularly in diastole, may fold upon itself and look like a tricuspid valve. I would say there is good evidence for congenital aortic valve disease because of the size of the left coronary artery, which is rather huge. The right coronary is quite small. This is supposed to occur in congenital aortic stenosis and is not typical of acquired aortic valvular disease.

The next film is five months after surgery. The heart is smaller. The pulmonary congestion is considerably improved, and the aortic valve prosthesis is in place, without excessive motion. The next film is six months after surgery. The heart has returned to its preoperative size of 16 cm., and we can identify a definite motion of the prosthesis in a 70° arc; it looks as though it were attached posteriorly and not anteriorly.

DR. SIRAK: From the preoperative film would you say that this is a moderately enlarged cardiac shadow here, Dr. Dunbar?

DR. DUNBAR: No more than moderate. I think it is much more suggestive of aortic stenosis than aortic insufficiency.

DR. SIRAK: Very good; this is the point I want to make. This patient had a diastolic murmur. This

patient is shown on the retrograde aortogram to have significant regurgitation of dye. So one would say, therefore, that his aortic insufficiency must be a really significant lesion here, but it is not the predominant lesion. The predominant lesion physiologically is his aortic stenosis. We have pretty good presumptive evidence of this in the fact that the patient's cardiac shadow is not markedly enlarged. Why do we say this? Aortic stenosis is a pressure work problem for the left ventricle. This causes a thickening of the wall, and because of the lower cardiac output an actual shrinking in the size of the cavity of the left ventricle. So the cardiac silhouette is small and yet this heart may be in serious trouble. With aortic insufficiency we have a large extra volume of blood which comes rushing back through the valve into the left ventricle. Therefore this increased blood would require a larger ventricular size. Aortic insufficiency is a flow work problem.

### Discussion of Catheterization Data

Let's look at the catheterization data now. In the left atrium the mean pressure was 24 while the normal value is around 6 mm. of mercury. I don't think that systolic and diastolic pressures really mean very much in the atria. The left ventricular pressure was 191/37 as compared to a normal of 120/6. We were always taught that an elevated endiastolic pressure meant ventricular failure whether it was left or right. This is probably not correct. This probably represents retained tension of the left ventricular fibers. Obviously, if this pressure were allowed to fall to zero, your mean perfusion pressure here would be inadequate to sustain adequate perfusion of the body. The endiastolic pressure can get much higher than this and the patients have no clinical signs of heart failure. Of course the left atrial pressure is going to have to rise above that point in order to maintain a filling pressure in the gradient throughout the valve. This pressure is then transmitted back to the capillary bed of the lungs into the pulmonary artery and causes a rise in the pressure of the right ventricle in order to drive the blood across the pulmonary bed.

You can see here that the systolic pressure in the right ventricle of this patient was elevated. The pressure in the aorta indicates to me that he had insufficiency but he also had a lowered systolic pressure due to the heart failure.

Now this patient had an aortic valvectomy, and this calcified bicuspid type of valve was excised followed by implantation of a Starr-Edward's prosthesis. This is done by open heart surgery using the heart pump and putting separate catheters into each of the coronary ostia so that the heart receives coronary flow throughout the period that the aorta is open and the myocardium does not become anoxic. The patient seemed to be doing well postoperatively until he developed this wound infection.

You can understand why a patient like this would



be more prone to infections because of his heart failure and consequent poor wound healing. However, his wound healed satisfactorily, his heart got smaller, and he had a good diastolic pressure. But in the sixth month his diastolic pressure began to sag again and he developed progressive aortic insufficiency, and the x-ray picture showed that his valve prosthesis had obviously torn from over half of his suture line. The patient went into heart failure and subsequently died. I think he probably developed a bacterial implant at the suture line and that the cause of his death was sepsis with consequent loosening of his aortic valve prosthesis.

#### CLINICAL DIAGNOSIS

1. Congenital bicuspid aortic valve with aortic stenosis and insufficiency.
2. Status 7 months post open heart surgery with replacement of valve by Starr-Edward's prosthesis.
3. Bacterial endocarditis with loosening of prosthesis, heart failure, and septicemia.

#### PATHOLOGIC DIAGNOSIS

1. Status 7 months post replacement of aortic valve by Starr-Edward's prosthesis.
2. Bacterial endocarditis and aortitis due to coagulase-negative *Staphylococcus*.
3. Mycotic false aneurysm of aortic sinus and ascending aorta.
4. Aortic insufficiency due to mechanical loosening of prosthetic valve.
5. Mechanical hemolytic anemia and septicemia.

#### DISCUSSION OF PATHOLOGY

DR. VON HAAM: The surgical incision showed two or three areas of breakdown in the scar with a little purulent drainage. The pericardial sac was nearly obliterated by dense adhesions and contained no fluid. The heart weighed 780 Gm. and showed marked hypertrophy of the left ventricle and moderate dilatation of the left atrium. The right atrium and right ventricle were distorted and displaced between the enlarged left heart and the fibrous adhesions surrounding the right posterior superior aspect of the heart. The myocardium of the left ventricle showed several areas of patchy fibrosis and measured 18 to 20 mm. in thickness.

#### Prosthesis Dislodged

The prosthesis was found in the aortic ostium but was freely movable. Only the sutures between the annular ring and the noncoronary sinus were intact. The sutures over the left coronary sinus were torn loose and the area covered by an organized thrombus attached to the aortic wall. In the right coronary sinus a large defect was found between the prosthesis and the aortic wall. Attached to the artificial ring was a large necrotic mass which apparently was

part of the aortic wall separated from the latter by a tear. Behind the tear a large pseudoaneurysm measuring 5 by 3 by 2 cm. extended between the ascending aorta and the wall of the right atrium. It was filled with fresh and clotted blood. The entrance to this aneurysm was covered by soft thrombotic material.

The rest of the aortic wall appeared intact and showed only small atheromatous plaques. The left coronary ostium appeared intact and measured 5 mm. in diameter. The right coronary ostium was narrow and the right coronary artery was markedly hypoplastic. The other valves appeared normal grossly. The mitral valve appeared dilated and measured 12 cm. in circumference. The lungs showed some edema and anthracosis. Frothy fluid was present in the smaller bronchi. The pulmonary vessels contained no thrombi or emboli. The spleen was enlarged and soft and contained two small abscesses. The liver showed moderate fatty metamorphosis and chronic passive congestion. The other organs seemed normal to gross examination.

*Microscopic examination* of the myocardium showed areas of patchy fibrosis surrounded by hypertrophic muscle fibers. The thrombotic material was composed of masses of fibrin with a few leukocytes. The edge of the rupture showed chronic granulation tissue extending through the entire thickness of the aorta into the adventitia. No bacterial colonies were found. Sections of the false aneurysm showed dense fibrosis with thick layers of fibrin containing many leukocytes. Sections of the lungs showed evidence of hemolysis, and sections of liver showed some septic necrosis of the parenchyma, as did sections of the spleen and kidneys. Bacteriological examination of the valves, blood, and splenic abscesses showed no growth after 48 hours' incubation.

In summary then, I am convinced that the patient suffered a dislocation of the valvular prosthesis secondary to bacterial endocarditis, and septicemia which however was not as overwhelming at the time of death as one might have suspected.

#### General Discussion

DR. RYAN: As you see, this case raises lots of problems. Some of us vacillate between euphoria and despair, because there are many heartaches in this field of cardiac surgery and valve replacements. This valve replacement is the best answer we have at the moment, but I think Dr. Sirak would agree that it is not the total answer yet. Once a patient with aortic stenosis becomes symptomatic he doesn't do well, he has a number of problems, and one is angina. The work load asked of his ventricle is such that even though the coronary arteries are bigger than normal and the coronary flow larger than normal, it isn't enough. They also have trouble with fainting, and they are quite prone to sudden death, very prone to arrhythmias. So when you see somebody begin to slip into failure with aortic stenosis you

know that in nine months to a year most of them will be dead. Since the placement of a prosthesis implies a good soil for bacterial implantation, should we treat all these people for two to three weeks with bacteriocidal levels of penicillinase-resistant penicillin as though they all had subacute bacterial endocarditis?

#### "Prophylactic" Antibiotics

DR. MACPHERSON: I think there are two points that should be made about this. The first is that when you do get an infection around any type of prosthesis in the vascular system it is virtually impossible to eliminate the infection. The second point is the question of the value of prophylactic antibiotic therapy. I would say that any time you use prophylactic antibiotics you tend to increase the number and the severity of an infection.

DR. SIRAK: I would just fortify these remarks by saying that over several years we ran a parallel

series of open heart procedures in which we did 100 to 150 with prophylactic antibiotics and then 100 to 150 without any antibiotic coverage at all, and the incidence of infection was essentially the same.

DR. PRATT: Is anybody going to comment on the patient's postoperative anemia?

DR. SIRAK: I think there are three good explanations for this. One is that the early postoperative anemia is a consequence of the dilution technic that we use in perfusion. Secondly, I think that the infection of his wound was another factor which contributed to his anemia, and certainly the detachment of the valve prosthesis was a third reason for anemia due to increased hemolysis.

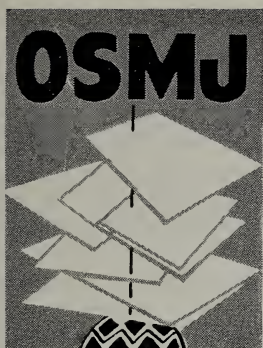
DR. RYAN: If you are going to have bacterial endocarditis, the aortic valve is probably the worst place to have it because of the progressive seeding of the coronary circulation with microscopic abscesses in the heart, which would further impair the myocardial function.

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**LOW BACK PAIN.**—Even after a formidable array of diagnostic procedures including myelography, the results of disc surgery cannot be predicted in patients with the group of symptoms and complaints variously known as low back syndrome, lumbago, sciatica, herniated disc syndrome, or sacro-iliac spasm or strain. As the author has pointed out, inflammation of structures around the greater femoral trochanter on the involved side is often the cause of this syndrome. Such cases can be easily diagnosed by injecting 2 per cent procaine into the peritrochanteric area. If procaine provides significant immediate relief, the condition is treated by instilling 40 mg. or more of methylprednisolone acetate into the same site simply by changing syringes. Procaine removes the spasm temporarily, and the steroid prolongs the spasmolysis. When 240 patients with the generally accepted criteria for diagnosis of the disc syndrome were given 1 to 12 injections of methylprednisolone acetate, 226 (94 per cent) obtained prompt and lasting relief. This diagnostic-therapeutic procedure is harmless, quick, accurate, inexpensive, simple to do, and requires no complicated equipment. It is far less complicated than the diagnostic studies ordinarily used to determine whether or not a herniated disc exists.

The author has used this method of treatment over a 5-year period in 240 patients of whom 54 had bilateral involvement. The syndromes were acute in 16 patients and chronic (1 month to 25 years' duration) in the remainder. Eleven patients had submitted to a total of 21 surgical procedures without relief. Most patients had been treated with salicylates, support, heat, and physiotherapy, without real improvement. Procaine regularly induced relief of pain, muscle spasm, and pelvic tilt for about two hours, after which about 50 per cent of the discomfort gradually returned. Pain and disability slowly diminished again over the next 18 to 24 hours, presumably as the microcrystals of the corticosteroid dissolved and exerted a local anti-inflammatory effect. One or more additional treatments were usually required for complete and enduring relief. A total of 226 patients could return to their former jobs and activities with comfort. Most of the remaining 14 patients did not return for a second injection after obtaining some transitory relief. No significant side effects could be attributed to methylprednisolone acetate, although as much as 120 mg. was sometimes used during a set of infiltrations. — (ABSTRACT), James C. Breneman, M. D., Galesburg, Mich.: *Arizona Medicine*, 21:635-639 (September) 1964.





# NEWS AND *Organization Section*

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## New Health Department Building Hinges on Bond Issue Vote

CITIZENS will be asked to vote on four issues in the coming election on May 4—a \$290 million bond issue, a guarantee for college student loans, a voter apportionment plan, and an industrial development program. Included in the bond issue is a provision for construction of a new Ohio Department of Health building.

Following is information regarding the bond issue as it pertains to the proposed Health Department building; also brief summaries of the other issues to go before the voters:

\* \* \*

The \$290,000,000 State of Ohio bond issue which will be on the ballot at the May election includes funds for a new Department of Health Building and Laboratory. These improvements are essential for the future of the State Health Department, according to Dr. Emmett W. Arnold, State Health Director.

"Our present State Health Department Laboratory, located on the campus of Ohio State University, is dangerously overcrowded and outmoded," Dr. Arnold said. "We have been forced to use hallways, closets, attic and basement for the conduct of tests. There is no room for expansion. In such quarters, protection cannot be adequate for laboratory workers who must handle dangerous germs, viruses, chemicals, and suspected radioactive materials in close proximity to other workers."

This laboratory, it was pointed out, serves all the people of Ohio. Private physicians as well as public health departments send specimens for analysis. The laboratory is an essential part of the State's bulwark against epidemics. It is a key unit for Ohio in an international surveillance network for such

communicable diseases as polio, tuberculosis, influenza, encephalitis, rabies and others.

The laboratory also runs chemical and physical tests in connection with environmental health problems, including air pollution, water pollution, radiation surveillance and atomic fall-out from the atmosphere, occupational health conditions, food and milk tests. It also provides a survey service for other laboratories throughout the state, such as those of local health departments, hospitals and industry, waterworks and dairies.

A further problem in connection with the present laboratory location is that Ohio State University wants and needs the space where it is located for an expansion of the University Medical Center which is scheduled within the next two years.

It is proposed to spend about \$5,000,000 on a new State Health Department Building. About \$1,000,000 would be available for the project from Federal Hill-Burton funds. Approximately half of the expenditure would go into the new laboratory and equipment. The other half would be for offices of the other divisions of the Ohio Department of Health which now are scattered in eight different locations in Columbus—some of them as much as three miles apart. The State is now paying more than \$100,000 a year for rental properties used by the Health Department.

The Governor's "Little Hoover" Commission last year recommended that facilities be provided to bring the various units of the Health Department into one location. It was estimated that another \$100,000 a year could be saved in the elimination of extra costs in telephones, mail handling, inter-office messenger

service, de-centralized filing, duplication of common services and general administration.

### Issues in Summary

The following is a resumé of the four issues commonly known as "The Ohio Plan for Jobs and Progress."

**Issue No. 1 — College Loans** — Voters will be asked to allow the State to provide guaranteed loans to assist Ohio college students. The Ohio Higher Education Assistance Commission would administer the program.

The loan program is already in full operation. However, there is some doubt as to the constitutionality of such a guarantee. This amendment would clear the legal status of student financial aid which was authorized by the 1961 Legislature.

**Issue No. 2 — \$290 Million Bond Issue** — In addition to the Health Department facilities, this amendment asks voters to authorize the issuance of \$290 million general obligation bonds to finance higher education construction, emergency public school building aid, park and recreation improvements, prisons, pipelines, airports, historical facilities and other public works.

This issue provides for \$7.5 million to get the Toledo Medical School program under way.

The bonds and interest would be repaid from the State's General Revenue funds.

**Issue No. 3 — Apportionment** — This is the apportionment plan of the Ohio Legislature, which provides equal representation in the Ohio Legislature for all people in accordance with the U. S. Supreme Court "one-man-one-vote." The February 1965 issue of *OSMJ* (p. 162) goes into detail on this subject.

**Issue No. 4 — Industrial Development** — This amendment provides an industrial development financing program such as now exists in 43 other states to encourage new and expanded industry to provide jobs without the use of taxpayers' money.

### Aerospace Medical Association Sponsors New York Meeting

The 36th Annual Scientific Meeting of the Aerospace Medical Association will be held in New York City, April 26-29, with headquarters at the New York Hilton Hotel.

Additional information may be obtained from the Aerospace Medical Association, Washington National Airport, Washington, D. C. 20001.

Parke, Davis & Company estimates that its film, "Going Our Way?" has been viewed by 30,950,000 people since its release in 1957. It touches on career opportunities in the professions of medicine and pharmacy. Another Parke, Davis film, entitled "Counter-Attack" documents the work of American medical teams throughout the world.

## Ohio and Other Studies Indicate An Increase in Alcoholics Among Mental Patients

Alcoholics, particularly those with the most severe forms of the disease, are increasing among State mental hospital admissions, according to Dr. Stanley F. Yolles, director of the National Institute of Mental Health.

A study by the Institute's Office of Biometry, Public Health Service, reveals that one in seven newly admitted patients is an alcoholic, an 18 per cent rise in 10 years. In nine states, disorders associated with alcoholism lead all other diagnoses in mental hospital admissions.

Recent figures analyzed by Ben Z. Locke, NIMH statistician, show a startling rise in the number of alcoholics diagnosed with "chronic brain syndrome associated with alcoholism," the most severe and hopeless of the three classifications of the disease. Patients in this group suffer permanent and irreversible destruction of the tissues of the brain. The damage probably results from metabolic or nutritional defects caused by prolonged use of alcohol.

These alcoholics undergo severe personality changes, delirium, confusion, amnesia, confabulation, or talkativeness about things that never happened, inflammation of the nerves, and pain in the arms and legs. The brain damage may be diagnosed by the electroencephalogram.

More than half the alcoholics now in State mental hospitals suffer from this irreversible form of alcoholism — a 50 per cent increase in this group in the past 10 years. This rise occurred during a period when the number of patients in mental hospitals has dropped. Patients in public mental hospitals in 1952 totaled 531,981 in contrast to approximately 495,000 today. Resident patient rates for these hospitals have dropped from 438 per 100,000 population in 1952 to about 359 per 100,000 now.

In contrast to the "chronic brain syndrome" patients, the other two classifications of alcoholics, "acute brain syndrome associated with alcoholism," and "sociopathic personality disturbance, alcoholism addiction," have grown at a much slower rate.

An analysis of one characteristic State, Ohio, furnishes this profile of the typical alcoholic admitted to a mental hospital: The odds are better than four to one that he will be a male, probably separated or divorced, with little or no elementary education. He is most likely to be admitted to the hospital for the first time, in his forties.

The person least likely to become an alcoholic patient, according to these statistics, is the married female with some college education, either under 35 or over 54 years of age. Figures from other States show that the Ohio profile accurately represents the national picture.



# County Officers' Conference ...

## Key Persons from County Medical Societies Confer in Columbus on Matters of Vital Importance to Medicine

THE 1965 County Medical Society Officers Conference, sponsored by the Ohio State Medical Association, was held in Columbus on Sunday, February 28, with persons present from 55 County Medical Societies and a total attendance of 187. All members of The Council except one were present and many of the AMA Delegates and Alternates attended the meeting.

Sounding the keynote with his talk, entitled "Forces Outside of Medicine Affecting Medicine," Dr. Robert E. Tschantz, of Canton, OSMA President, drew a sharp contrast between the Eldercare program sponsored in Congress by the medical profession and the Medicare program promoted by the administration in Washington.

Dr. Tschantz praised medical organization groups and lay personnel associated with the profession for the efforts that are being made in behalf of Eldercare, but added that there are "pockets of resistance" in certain areas.

What are the forces outside of medicine affecting medicine? The forces that can bring about the

greatest reversal in the American system of medical practice are those centered in efforts to put over the King-Anderson-type of legislation. Already, Dr. Tschantz pointed out, the federal government has gone far toward gaining control of areas of health and medical care. Twenty-five per cent of medical care and research is paid for by the federal government; 30 million people are getting all or part of their medical care from government; as much as 40 per cent of medical school faculty costs are being paid for through federal funds, etc.

The ultimate objective, Dr. Tschantz said, quoting from the *Congressional Record*, is to bring all phases of medical and dental care under the control of the federal government through the Department of Health, Education and Welfare and through the Social Security System.

### Ohio Legislation

Hart F. Page, Executive Secretary of the OSMA, discussed the Ohio General Assembly, now in session, and legislation involving medicine.

Mr. Page complimented physicians for their part



Five participants in the Conference program are shown. At rostrum, Clarence V. Tittle, Jr., Chief of the Ohio Division of Aid for the Aged. Standing, left to right, are: Dr. Ernest B. Howard, Chicago, Assistant Executive Vice-President of the AMA; Hart F. Page, OSMA Executive Secretary; Dr. Robert E. Tschantz, Canton, OSMA President; and Aubrey D. Gates, Director of the Field Service Division, AMA.

in defeating the proposed bill in the Ohio General Assembly that would have extended the statute of limitations from one to two years for malpractice and other actions. The bill was killed in committee after numerous medical groups and other interested organizations testified through their representatives against the measure.

Mr. Page commented on a number of bills of medical and health interest now before the Ohio General Assembly and on the Governor's message recently before a joint session of the House and Senate. Information on these points has been distributed through the Legislative Bulletin of the Association to County Medical officers, legislative committee chairmen and other key persons in local areas.

#### AMA's Health Care Plan

Dr. Ernest B. Howard, Assistant Executive Vice-President of the American Medical Association, was in Columbus to speak by special invitation of the Association.

Dr. Howard discussed the AMA-supported Elder-care program now before Congress and said that this form of legislation is receiving greater support than ever before from newspapers and other news media. The Eldercare program is receiving more and more public support because of the following principles involved in it, he said:

The need issue, as opposed to health care at public expense for everybody over age 65;

The "total package" it gives elderly persons who are in need of health and medical care;

The "reasonable cost" issue, since it would apply only to those who need public assistance;

Administration by the state as opposed to federal control;

The use of insurers already well-established in the health care field;

The fact that federal funds could come out of the general budget as opposed to payroll deductions.

Dr. Howard deplored what he termed the two most

disturbing elements in regard to the administration-backed Medicare program: The attitude of many leaders and the backing of businessmen for a payroll deduction to support a medical-health program. He urged physicians to use all persuasion possible to combat these attitudes.

The general public is familiar with the word Medicare, Dr. Howard said, but numerous polls show the average person does not know what the Medicare program contains.

Radicalism in politics has not taken over, Dr. Howard insisted, stating that editorial comments and other signs indicate that conservatism is still a force in the American way of life. To confirm this viewpoint, he read from a recent editorial in the *Chicago Tribune* to the effect that the Medicare concept of health care is eroding in public opinion.

#### Grassroots Action

An on-the-spot picture of what is going on in Washington was brought to the conference by Aubrey D. Gates, director of field services for the AMA, who has been in close touch with Congress.

Under the topic, "The Physician, the County Society and Grassroots Action," Mr. Gates said that after the introduction of the Eldercare bill in Congress, mail on the subject has been going to Washington in increased amounts.

He urged physicians to picture their Congressmen and Senators in the light of the climate in which they must operate. This climate for any one member of Congress is threefold, he said: (1) that of his constituents which is most important; (2) that of his fellow Congressmen with whom he must deal for his influence; and (3) the climate of the administration, which to a great extent controls patronage.

Try to win your Congressman to your point of view 100 per cent, Mr. Gates said, but if you can win him only 10 per cent at least you have accomplished something.

The most ardent supporter of medicine's program in Congress needs mail to back up his arguments, Mr.



*This is part of the audience of more than 180 persons who attended the Conference and heard discussions on matters of vital interest to the medical profession.*



Gates emphasized. Conversely, the greatest opponent will be influenced by mail from his constituents.

Mr. Gates urged physicians to present medicine's point of view to any and everyone who has to do with moulding public opinion—local public officials, mayors, sheriffs, judges, editors, TV and radio announcers; even the barber and service station attendant.

Mr. Gates concluded his remarks by saying that he was delighted with the medical profession's promotion of the Eldercare program among Congressmen to date.

### Promotion of Annual Meeting

Dr. Jack Schreiber, Canfield, chairman of the OSMA Annual Meeting Attendance Committee, discussed ways of increasing interest in the 1965 OSMA Annual Meeting in Columbus, May 9-14.

A magician in his own right, Dr. Schreiber used some showmanship to illustrate the serious side of promoting more interest in the OSMA Annual Meeting to be held in Columbus, May 9-14. "Medicine and the Whole Man," is the theme of the meet-



*Members of the "Eldercare Trio" of Youngstown who inspired the audience with their Eldercare parodies are shown here with their accompanist, Dr. John H. Budd, Cleveland. The senior high students are Diane Babnick, Donna Marrie Geise and Kathy Sofranec.*

ing to highlight a program that is planned for physicians in all branches of practice. Meetings of the House of Delegates bring into the meeting the element of a voluntary government through which any member of the Association may be heard.

Dr. Schreiber urged action in each county to center more interest in the Statewide program. Individual members were urged to invite interns and residents to come with them, to form caravans of local groups or at least to invite one or two other members to share a car.

Dr. Schreiber also referred to the entire program

printed in the March issue of *The Journal* and literature explaining features of the meeting being sent from the Columbus office.

### Regional Hospital Planning

Dr. William R. Schultz, Wooster, chairman of the OSMA Committee on Hospital Relations, discussed the topic, "The Physician and Regional Hospital Planning in Ohio."



*Three additional participants in the Conference program are shown here, left to right, Dr. William R. Schultz, Wooster, Chairman of the OSMA Committee on Hospital Relations, Dr. Henry A. Crawford, Cleveland, OSMA President-Elect; and Dr. Jack Schreiber, Canfield, Chairman of the OSMA Annual Meeting Attendance Committee.*

In areas where the acute shortage of hospitals has been satisfied to some extent, areawide planning is taking over, Dr. Schultz said. More discriminate planning is brought about also, he said, by the rising cost of construction and expansion.

Dr. Schultz urged physicians to take part in areawide planning of hospitals and County Medical Societies to participate in such programs.

He called attention to the First National Conference on Areawide Health Facilities Planning held recently in Miami Beach, Florida. An important point brought out at this meeting and urged by the American Medical Association is that all such community planning should be done on a voluntary basis. (Additional information will be published in *The Journal* on the address of Dr. Schultz.)

### Aid for Aged in Ohio

The Association was fortunate in having as guest speaker at the Conference Clarence V. Tittle, Jr., chief of the Ohio Division of Aid for the Aged, who discussed "Ohio's Aid for the Aged Program—Scope, Services, policies."

Mr. Tittle called attention to the fact that Ohio has an aid for the aged program that goes back farther than the national Social Security program.

It was established to provide assistance to persons 65 years of age or older who request the service and who are in need.

Mr. Tittle explained the two sections of this program: (1) the assistance program for those who are unable to meet the costs of living including health care costs; and (2) the "medical only" program for those who can pay their living expenses but are unable to pay health care costs.

(The full text of Mr. Tittle's address appears in this issue beginning on the next page.)

#### District Conferences

An important part of the conference was devoted to District Conferences, during which physicians from each of the 11 areas of the State met with their Councilors to discuss matters of local particular interest. A separate conference also was held for AMA Delegates and Alternates, over which Dr. John H. Budd, of Cleveland, chairman of the Ohio delegation, presided.

Dr. Henry A. Crawford, Cleveland, President-Elect of the Association, presided at the afternoon session, while Dr. Tschantz presided during the morning session.

A complimentary luncheon was served in the Saturn Room of the Columbus Plaza Hotel.

Added attraction at the luncheon was the appearance of the "Eldercare Trio," a group of senior high school students of Youngstown, who entertained with vocal selections and two parodies on Eldercare. They are Kathy Sofranec, Donna Marrie Geise and Diane Babnich. Dr. John Budd, of Cleveland, accompanied the trio on the piano. Dr. John J. McDonough, president of the Mahoning County Medical Society, wrote the words for the parodies.

#### Ohio Academy of Science To Meet in Athens

The 74th Annual Meeting of the Ohio Academy of Science will be held on the campus of Ohio University, Athens, Friday and Saturday, April 23 and 24. The Medical Science Section will hold its meeting on Friday, April 23.

Members of the Ohio State Medical Association have been issued a special invitation to attend the Medical Science Section. Physicians who wish additional information may contact C. Glenn Barber, M. D., Corresponding Secretary, Section D., whose address is 606 Hanna Building, Cleveland, Ohio 44115.

Executive offices of the Ohio Academy of Science are in the Battelle Memorial Institute, 505 King Avenue, Columbus, Ohio 43201.

The American College of Gastroenterology has announced its annual postgraduate course to be held in Bal Harbour, Florida, October 28-30.

## Carroll County Society Announces Postgraduate Day May 19

The Carroll County Medical Society is sponsoring its first annual postgraduate day program on Wednesday, May 19, at the Atwood Yacht Club near Dellroy, 20 miles east of New Philadelphia.

Physicians in the Seventh Councilor District are on a mailing list to receive additional information about this meeting with an invitation to attend. All physicians are welcome and those who wish more information may contact Thomas J. Atchison, M. D., Secretary of the Carroll County Medical Society, 292 E. Main Street, Carrollton.

Application has been made for Category I credit for general practitioners who attend this meeting.

Tentative plans are to hold future meetings at the new Atwood resort area Lodge, which will be included on a tour this year.

## New Members...

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during February. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

#### Athens

Donald H. Brown, Athens  
John DeLisio, Nelsonville  
John J. Smith, Athens

#### Butler

Omer C. Hurlburt, Middletown

#### Coshocton

Donald E. Potts, LaFayette

#### Cuyahoga

Juan M. Gonzalez, Cleveland  
Herbert G. Jakob, Cleveland  
Arnold I. Rosenzweig, Cleveland  
Thomas C. Rohweder, Cleveland

#### Delaware

David R. Smith, Jr., Delaware

#### Fairfield

David H. Sheidler, Lancaster

#### Franklin

James W. Keller, Columbus  
Ralph G. Rohner, Jr., Columbus

#### Geauga

Wei-Tien Pien, Chardon

#### Huron

Phillip E. Bently, Wakeman  
Phillip K. Wood, Norwalk

#### Lake

Marvin A. Feldstein, Mentor  
Donald M. Patchin, Mentor

#### Logan

Gerald E. Munn, Bellefontaine

#### Lucas

Randall L. Finken, Toledo  
Robert P. Sheon, Toledo

#### Marion

Valeriano Jamora, Jr., Marion

#### Mahoning

William R. Torok, Youngstown

#### Montgomery

Thomas P. Beach, Dayton  
John H. Dirckx, Dayton  
Martha E. Ebbrecht, Dayton  
Harold Fishman, Dayton  
Marcus J. Freese, Dayton  
Stanley L. Garber, Dayton  
George W. Lechner, Dayton  
Richard J. Paulus, Dayton

#### Ottawa

Norman Claybourn, Elmore

#### Pickaway

Lloyd R. Covault, Jr., Orient

#### Richland

Enrique Aguado, Mansfield  
Thomas W. Howell, Mansfield  
J. Bruce Jackson, Mansfield

#### Sandusky

Willis L. Damschroder, Gibsonburg

#### Scioto

Sheldon Rogers, Portsmouth

#### Trumbull

Lewis P. Sarkos, Warren  
Corrado Sartarelli, Warren

#### Williams

John E. Moats, Bryan  
Alexander Zasidatel, Montpelier

#### Wood

Douglas S. Hess, Bowling Green



# Aid for the Aged in Ohio...

## How the Public Assistance Program Works in This State: Extent of Coverage; Its Administration, and Other Data

By CLARENCE V. TITTLE, Jr., Chief,\*

Division of Aid for Aged, Ohio Department of Public Welfare

THE Ohio Aid for the Aged Program began in 1934 when it was enacted as a result of an initiative petition passed by a popular vote of the people. It was enacted into being a year and a half before the original Federal Social Security Act.

The first appropriation for Ohio's Aid for Aged Program was exclusively financed by state funds. Since February, 1936, it has been financed by state and federal funds on a matching basis. The program is administered by the Division of Aid for Aged, State Department of Public Welfare, and has an office located in each of the 88 county seats in the state. It is the only public assistance program administered by the state. The 1963-64 appropriation approved by the state legislators for the Aid for Aged Program was ninety million dollars. The appropriation was divided between two major programs—Health Care and Regular Assistance Programs. Twenty million dollars were allocated to Health Care and seventy million dollars for the Regular Assistance Program.

### Significant Change in 1956

While the Aid for Aged Program has, since its beginning, made provision for meeting the health care needs of the aged, a most significant change was made in 1956 when the legislators enacted several laws to expand the Aid for Aged Program to make possible the recognition of health care as an extraordinary need without a ceiling on payments. This permitted the Division to establish a Health Care Program to meet the health care needs of many aged persons who have the ability to meet their daily living expenses for food, clothing, shelter and other items. Now there are about 4,000 aged persons in this state receiving this health care assistance each month through what we call our Medical Only Program. Health care services also are provided each

year to 67,000 to 72,000 aged persons who are also receiving regular assistance.

Many can recall that prior to 1956, allowances for health care were included in the recipient's budget, and the total for this item of need could not exceed \$200 per year. Since then, there has been no dollar limit on the amount required for necessary health care. There are limitations on the amount that can be charged for various health care services, and these are determined by a fee schedule. As you well know, a wide array of health care services are available to the recipients.

This briefly is an overview of the development of the Health Care Program; but in order to understand better the importance of the program, I would like to point out several trends taking place in the nature of Aid for Aged caseload.

A review of the caseload since 1934 reveals that several trends are taking place. The caseload of those in need of regular assistance peaked up to 127,106 persons in January, 1950, and has descended downward to 78,665 recipients in December, 1964. The average age of the applicant has gone up to 72 years of age, and that for the recipient to 79 years. It is anticipated that the average age of the recipient will reach 80 years within the near future. While the caseload is declining, and an older person is being served, we find a rapid increase in the number of aged persons requiring assistance to meet many kinds of health care needs.

### Aging Population Increases

This can be clearly seen in the very rapid increase in the number of aged persons requiring assistance to enable them to receive nursing home care. Before 1956, the total number of Aid for Aged recipients receiving care in nursing homes was less than 2,500. Today, there are nearly 12,600 recipients in nursing care homes. Our experience indicates there will be

\*From an address by Mr. Tittle at the Ohio State Medical Association 1965 County Medical Society Officers Conference, Columbus, February 28, 1965.

an annual increase of 500 to 600 aged persons needing financial assistance to permit them to obtain long term care in nursing care homes. Presently, the annual expenditure of public assistance funds for nursing home care is \$16,800,000. On July 1, 1965, it will reach \$18,300,000 when the ten dollar per month increases go into effect. I will not dwell on nursing home care further, other than to offer you assurance that we are considering three or four plans to improve our program.

How large is the Health Care Program? A look at the payments made for health care services during the fiscal year ending June 30, 1964, offers an insight into its size and the variety of services. We know from the claims submitted that physicians offered their services at least 275,000 times for which we paid \$2,624,000. Our statistics fail to show how much of your services you provided without charge, or the extent of services that cannot be measured in any manner. For other practitioners, 25,000 claims were submitted for \$120,000 payment. For hospital care 42,700 claims were submitted which represented over 400,000 days of hospital care. The cost of this care was \$12,753,000. An Aid for Aged recipient stays in a hospital an average of almost 14 days per stay. The provision of drugs and supplies which you prescribe cost \$4,676,000. If you wonder why you have to wait for your payment, you may appreciate the fact that over 1,075,000 claims were submitted for drug items alone.

Approximately one and a half million claims for all services were submitted for payment during the 1963-64 fiscal year. The total cost for all of the health care services was approximately \$20,000,000 in that year. This provided services to 67,000 to 72,000 aged persons receiving public assistance, in addition to the 3,500 to 4,000 aged persons a month on the Medical Only Program.

I have made several references to a Medical Only Program, Regular Assistance Program, and Health Care Program. I am sure that these references are confusing to you and I know they are not fully understood by the public. I feel at times that too many members of the Aid for Aged staff do not clearly understand the relationship of one to the other.

#### **Kerr-Mills Explained**

The Medical Only Program was made possible through provisions of the Kerr-Mills Act. The legislators of Ohio, and the administration of the State Welfare Department did not accept the Medical Assistance for the Aged Programs as provided in the Kerr-Mills Act. Rather, they selected the provision of the Act which permitted the states to make money payments on behalf of a recipient to another person who has provided health care services to the recipient. The state legislators and the administrators also selected the provision of the Kerr-Mills Act which made it possible to recognize health care as an extraordinary need — one that exceeds the financial ability

of a large number of aged persons to maintain themselves on a day to day basis.

While Ohio does not have a Medical Assistance for the Aged, it has taken advantage of several provisions of the Kerr-Mills Law. One question that I am continually asked is "Would Ohio have a better Health Care Program if it had Medical Assistance for the Aged?"

There is no doubt that by having a M. A. A. Program there would be a greater number of persons eligible for health care assistance through liberalization of eligibility requirements by removing the residence requirement and the lien laws. We know that the removal of the lien law would add 10,000 aged persons to our rolls. We do not know how many would be aided by removing the residence requirement.

The argument that by having M. A. A. Program, Ohio would gain in federal matching funds has little merit. To do so in this manner would mean an additional state appropriation that would offset any such gains. It has been our opinion in the Welfare Department that to adopt an M. A. A. would mean that we would have to be restrictive by placing drastic limitations on the amount and kinds of health care services necessary to meet the demands made by a sharply increased caseload. Many of the states that have liberalized their eligibility requirements have very limited health care programs. One state only permits three (3) days of hospital care. Recently a large state had to curtail drugs and other services because of overspending.

#### **Helps Those Needing Help**

Ohio's Medical Only Program does make it possible for those who are unable to assume the burden of paying for health care costs to have such needs met through the Aid for Aged Program. The payments for such services is made on their behalf to you, the hospitals, druggists, and other health groups.

We have reason to believe that it is a successful program. Last fall I worked very closely with Mr. Charles Edgar and Mr. Hart Page of the OSMA staff to handle inquiries that resulted from your, the Ohio State Medical Association, education campaign which called the specific attention of the aged population to the services offered by the insurance programs and the Aid for Aged Programs. There was a rather heavy response from persons who made inquiry or expressed desire to receive necessary services. In only one case did we find that services were not available in this state to meet the health care needs. This was a most questionable case since the person only very recently moved from another state to Ohio and the health care needs did not appear to be of an emergent nature.

I was very impressed by the concern your staff revealed for the people in this state. I was also impressed with their promptness in responding to you



and to those who made inquiries about the various programs. It was a most rewarding experience for me.

Who is eligible for Aid for Aged assistance?

1. 65 years of age or older.
2. Has been a resident of Ohio for three (3) out of the last nine (9) years with one year continuous residence immediately prior to application.
3. Who is in need because he does not have sufficient income or resources for support, including health care costs, and does not have available support from a spouse or child. (\$84.50 is recognized as the basic amount for food, clothing, rent, and utilities for a single person. Other needs are determined in addition to this amount for a single person living alone. This amount varies considerably according to different living arrangements and various needs).
4. Who is not living in a public institution, except as a patient in a public medical institution or an inmate of a city or county home.
5. Whose real estate is not worth more than \$12,000. The law requires that both the recipient and the spouse sign a certificate of lien whenever they own an interest in real property. The title is retained by the individual.
6. A person may retain insurance when its value is \$500 or less. Insurance in excess of \$500 must be trusteed to the Division.

These, briefly, are the eligibility requirements for Aid for Aged Program. They are the same for the Medical Only Program and the Regular Assistance Program.

### Area of Misunderstanding

Now I would like to give attention to an area where there is misunderstanding, and that is in regard to the rules and regulations of the Division as they relate to you. The staff is instructed, through a written policy, that the private relationship between the physician and recipient is to be respected and protected. The Division enters into this relationship only to the extent required to establish need because it is a tax supported program and to formulate a plan to meet this need within available funds. The caseworkers are instructed to understand clearly that the recipient is the patient of his physician and not of the Division. This is the basic philosophy of the Division.

I do not believe that we have a rule or regulation that intervenes in your professional physician-patient relationship. The rules and regulations that we do have relate to billing for services rendered and the payment for your services according to a prescribed fee schedule. You are required to bill in triplicate, and the statement should show the recipient's name, address, diagnosis, acute or chronic conditions, date of service, and fees charged. The billing is to be submitted to the Subdivision Offices within ninety (90) days from date of service. Payment can be

made only for no more than two visits for a chronic illness and not more than ten visits for an acute illness during any one month.

All of these regulations are necessary under present accounting and audit procedures to establish a proper claim against the state. We do have under consideration some methods of simplifying procedures. In case of any dispute, you have the right to request a hearing to appeal the decision made by the Division.

### Any Just Claim Proper

It has been my policy that any just claim is proper, and that no one should suffer or be aggrieved as a result of negligence on the part of an employee of the Division. If you should have any feelings of this nature, do not hesitate to correspond with my office.

I will not take the time to review the fee schedule since it is available in a published form, Medical and Surgical Fee Schedule Applying to New Health Care Program of Ohio Division of Aid for the Aged. I will send the information to any one desiring to have it.

Supplementation is not permitted because of federal regulations that discourage such a practice. The Division recognizes the payment for your services by the recipient or a relative as full payment.

In conclusion, I wish to offer my appreciation to you and your colleagues for the valuable services which you are rendering to the needy persons in this state. While our program is far from being perfect or ideal, I believe that we have one of the finest health care programs in this nation. It is only through our working together that we can improve upon existing programs by more effectively utilizing the available resources and services. You should be proud of your profession and your state organization, and be pleased with your contributions to society. My greatest desire is that more of your colleagues offer their invaluable talents to recipients in our program.

### Postgraduate Programs Scheduled At Ohio State University

Ohio State University College of Medicine has scheduled a number of postgraduate programs, among them the following:

Anesthesia — April 23-24.

Second Annual Kidney Symposium — May 26.

Occupational Medicine — June 7-11.

Additional information may be obtained from The Center for Continuing Medical Education, 113 Hamilton Hall, 1645 Neil Avenue, Columbus, Ohio 43210.

Featured speaker for the March 9 meeting of the Fort Steuben Academy of Medicine was Dr. Walter H. Judd, well-known physician-congressman who discussed the topic, "Doctors in A Changing World." The dinner meeting for physicians and their guests was held at the Fort Steuben Hotel, Steubenville.

# Resolutions Which Will Be Considered At the 1965 Annual Meeting

HERE are the texts of resolutions which will be presented for consideration of the House of Delegates at the 1965 Annual Meeting of the Ohio State Medical Association the week of May 9 in Columbus. These resolutions were received at the Columbus Office on or before March 10, thereby meeting the 60-day deadline. No resolution which failed to meet the 60-day deadline may be introduced unless the sponsor secures at least a two-thirds consent vote of the delegates present at the meeting.

Copies of all resolutions presented to the Columbus Office will be sent to individual delegates so they may discuss them with their county medical societies if they care to do so.

A resolution to be considered by the House of Delegates must be typed in triplicate; introduced by a delegate or his duly accredited alternate seated in his place; and introduced at the first session of the House of Delegates. This procedure must be followed even though the resolution may have been published in *The Journal* or sent in writing to all delegates prior to the meeting.

Sessions of the House of Delegates will be as follows: First session, Sunday, May 9, 6:00 P. M., EST, Saturn Room, Columbus Plaza Hotel. Second Session, 6:00 P. M., Saturn Room, Columbus Plaza, Tuesday, May 11. Meetings of the Reference Committees on Resolutions will be held all day on Monday, May 10, and on Tuesday morning, May 11, if necessary.

## RESOLUTION NO. 1

### Increase in OSMA Dues

(Submitted by The Council of the Ohio State Medical Association)

WHEREAS, At the 1965 Annual Meeting of the Ohio State Medical Association the delegates will act on a resolution to waive dues for members over 70 years of age on their request and such an amendment, if presented, will result in a marked decrease in revenue to the Association; and

WHEREAS, The Association is faced with the situation in which expenses are rising but income is not increasing, making it necessary to include income from previous years to bring the 1965 budget into balance; and

WHEREAS, Ohio is currently one of three state medical associations with the lowest dues in the country; and

WHEREAS, Medicine faces its time of greatest challenge, and has found it necessary to expand existing programs as well as to initiate additional activities;

THEREFORE, BE IT RESOLVED, That the per capita annual dues of the Ohio State Medical Association be in-

creased \$15 effective January 1, 1966, making the total amount of annual dues \$50.

(For details, refer to March issue of *The Journal*, beginning on page 284.)

## RESOLUTION NO. 2

### Environmental Heat and Athletics

(By the Ashland County Medical Society)

WHEREAS, Football practice in Ohio high schools and colleges is conducted during August and September when the heat and humidity are significantly high, and

WHEREAS, Heat stroke has been the cause of avoidable fatalities in football practices in Ohio and the nation each year, and

WHEREAS, Heat stroke deaths are preventable if proper precautions are taken, now therefore,

BE IT RESOLVED, That each county medical society take an active role each summer to provide medical leadership at the school level in the education of coaching staffs and, furthermore, the society should make certain that there is direct supervision of personnel concerned with assessing heat and humidity on the football field in order that practice schedules may be altered when the condition warrants it, and be it further

RESOLVED, That a preseason conditioning program be encouraged, including water and salt available on the field; that a program be instituted at each school for the prevention of problems with environmental heat, and be it further

RESOLVED, That the Ohio delegation to the American Medical Association introduce this resolution at the next session of the House of Delegates of the American Medical Association.

## RESOLUTION NO. 3

### Osteopathy

(By the Summit County Medical Society)

WHEREAS, In our opinion no uniform and state-wide policy governs professional relations between physician-members of the Ohio State Medical Association and doctors of osteopathy and that we believe this to be desirable, and

\*WHEREAS, The House of Delegates of the American Medical Association has clearly delegated to the state associations a key responsibility in this field of policy making, and

WHEREAS, There are only about thirteen-hundred licensed doctors of osteopathy in the State of Ohio as compared to approximately eleven-thousand licensed medical doctors, indicating that leadership in this matter should be retained by the Ohio State Medical Association rather than by the Ohio State Osteopathy Association or comparable group, and

WHEREAS, It is our aim to combine into one fellowship all who practice ethical and scientific medicine, therefore

BE IT RESOLVED, That Ohio delegates to the American Medical Association institute proposals calling on the American Medical Association to work toward standardization and accreditation of undergraduate and postgraduate training for doctors of osteopathy directly through its own committees as well as through its representatives and delegates to other accrediting bodies, and

BE IT FURTHER RESOLVED, That this House of Dele-

\*House of Delegates, AMA, 1961.



gates pursuant to the Constitution and By-Laws which require that matters of ethics be referred to Council, request the Council of the Ohio State Medical Association to develop a plan of action for this House to approve or disapprove at its annual meeting in 1966 detailing a program and mechanism to aid the development of customary internships and residencies for doctors of osteopathy who signify their intent to join county and state medical societies, and

BE IT FURTHER RESOLVED, That this plan include procedures for subsequently determining by examination whether or not the individual osteopath graduate is capable in fact of practicing a method of healing founded on a scientific basis, and

BE IT FURTHER RESOLVED, That this plan include provision for inviting all Ohio osteopaths so inclined to voluntarily apply for such training, accreditation and discipline under the principles of medical ethics, and

BE IT FINALLY RESOLVED, That said plan include a schedule of constitutional and by-laws changes and public legislation aimed not only at establishing membership for qualified osteopathic physicians in the Ohio State Medical Association but also designed to bring about a single, licensed, qualified medical profession in the state of Ohio — all this in the best interest of the public.

#### RESOLUTION NO. 4

##### Architectural Barriers

(By the Academy of Medicine of Cleveland)

WHEREAS, Public buildings are constructed for the purpose of serving all of the Public, and

WHEREAS, The architectural design of many public buildings includes such things as narrow elevator doors, narrow corridor doors, long steep flights of steps and other things which impede the movement of handicapped persons in and around such public buildings, therefore

BE IT RESOLVED, That this problem be brought to the attention of proper public officials so that new construction and remodeling will include such modification in design so as to make the movement of the handicapped easier.

#### RESOLUTION NO. 5

##### Mental Health Program

(By the Summit County Medical Society)

WHEREAS, Physicians have long been leaders in the field of treatment and prevention, of mental illness, and that they alone are capable of providing complete, comprehensive care, and

WHEREAS, The American Medical Association has identified mental illness as America's most pressing and complex health problem and that every physician, regardless of type of practice, has an important stake in improving our mental health knowledge and resources, and

WHEREAS, The American Medical Association in its First and Second Congresses on Mental Illness and Health and in its Statement of Principles on Mental Health, has emphasized the need for medical societies and physicians at every level to promote community mental health programs for treatment and prevention of mental illness, and

WHEREAS, The Ohio State Medical Association in its 1964 delegate assembly reaffirmed the leadership role of the physician in mental health planning programs by its passage of resolution No. 14, therefore

BE IT RESOLVED, That the 1965 delegate assembly acknowledge the efforts of the Committee on Mental Health of the OSMA in establishing a program, and

BE IT FURTHER RESOLVED, That the Council continue to support the Committee on Mental Health so as to effectively involve the component societies in active participation in community mental health planning and programs, and

BE IT FURTHER RESOLVED, That to accomplish such participation, a state-wide conference of county mental health committee chairmen and officers, be held within the current year to provide information on community mental health services and to effect a coordinated effort on the part of component societies.

#### RESOLUTION NO. 6

##### Need for General Practitioners

(By the Huron County Medical Society)

WHEREAS, There has been a steady decline in the number of medical doctors entering general practice in the past several years; and

WHEREAS, The population steadily continues to increase thus the relative general practitioner-population ratio continues to decline; and

WHEREAS, The medical schools continue to encourage more medical doctors to enter research and specialty fields; and

WHEREAS, The rural, suburban and small community areas are suffering most from a lack of qualified medical doctor generalists; and

WHEREAS, This need is becoming filled by members of the other healing arts; and

WHEREAS, The public image of the medical profession is suffering already, therefore

BE IT RESOLVED, That the Ohio State Medical Association go on record as favoring and encouraging a strong drive to influence the medical schools of Ohio to encourage more young medical doctors to enter into general practice and honor this group with dignity and respect.

#### RESOLUTION NO. 7

##### Blue Shield's (OMI) Association With Blue Cross Plans

(By the Summit County Medical Society)

WHEREAS, For many years subscribers have identified the Blue Shield Program with the Blue Cross Plans in Ohio, and

WHEREAS, Our Blue Shield Plan itself has now expressed concern similar to that felt for many years by this county medical society over the many misconceptions and misunderstandings in the minds of these subscribers, and

WHEREAS, The public as a whole and even many physicians do not clearly separate the two groups in their thinking, and

WHEREAS, These two companies are separately owned and governed, cover totally different areas of medical expense and oftentimes may represent conflicting philosophies of prepaid health insurance, therefore

BE IT RESOLVED, That the administrative duties performed by the seven Blue Cross Plans in Ohio for our Blue Shield Program (OMI) including the issuance, distribution, servicing and particularly the sales of Blue Shield (OMI) contracts be performed as of January 1, 1966 by Blue Shield itself.

#### RESOLUTION NO. 8

##### Exemption from OSMA Dues

(By the Academy of Medicine of Cleveland)

WHEREAS, Some physician members of the Ohio State Medical Association may experience drastic financial emergencies due to family illness, accident, or other cause, and

WHEREAS, These members may earnestly desire to retain membership in their Ohio State Medical Association but find payment of the regular dues constitutes a genuine financial hardship, and

WHEREAS, These members may not qualify for dues exemption under paragraph 2 of Section 1 of Chapter 2 of the Constitution and By-Laws of the Ohio State Medical Association, therefore

BE IT RESOLVED, That, in addition to the present provisions regarding dues exemptions as provided in paragraph 2, Section 1, Chapter 2 of the Constitution and By-Laws of the Ohio State Medical Association, an appropriate amendment be prepared by the Legal Counsel, under the supervision of The Council of the Association, to incorporate the following:

A member of the Ohio State Medical Association for whom payment of the regular dues constitutes a financial hardship may be granted an adjustment of dues, for a specified period of time, to meet his specific problem upon

approval of the Council of the Ohio State Medical Association provided:

(a) That such member present a written formal request for dues adjustment, and

(b) That his request has been approved by his local society and certified to the Ohio State Medical Association by the Secretary-Treasurer of the local society.

#### RESOLUTION NO. 9

Eldercare Act of 1965

(By the Trumbull County Medical Society)

WHEREAS, The elderly citizens of the United States, and particularly those over age 65, deserve and require comprehensive health care, including medical and surgical services, hospitalization and nursing home care, and defrayment of drug costs as a prerequisite to retention of good health

WHEREAS, The physicians of the United States, and their respective medical organizations recognize this need and are totally in accord with it

WHEREAS, There was introduced into the 89th Congress identical bills simultaneously by Representatives Herlong (D) Florida, and Curtis (R) Missouri, entitled "Eldercare Act of 1965" which permit the various states to assist in providing health care for all elderly citizens under voluntary private health insurance plans to be financed under the existing Kerr-Mills law with federal-state funds from general revenue sources.

BE IT RESOLVED, That if and when the "Eldercare Act of 1965" becomes law, that the OSMA utilize its fullest powers to assist and encourage the State of Ohio to implement this Act to its fullest extent to make available to all elderly citizens over 65 residing within Ohio, the complete health care provided through voluntary private insurance plans as envisioned by this resolution.

#### RESOLUTION NO. 10

Uniform Policy for Ohio Medical Indemnity Contract

(By Academy of Medicine of Cincinnati)

WHEREAS, The practice of radiology has been acknowledged as the practice of medicine by County Medical Societies, State Societies and the American Medical Association, and

WHEREAS, Blue Cross has been paying hospitals for the taking of x-rays when such x-rays could be taken in the office of the physician if payment were made by Blue Shield for radiologic services, and

WHEREAS, Payments are made by Ohio Medical Indemnity, Inc., under the Comprehensive Contract, and

WHEREAS, Payments are denied to physicians under the Standard and other contracts of Ohio Medical Indemnity, Inc., which are sold in conjunction with Blue Cross in many Ohio counties, and

WHEREAS, The physician can perform a convenient and economic service for patients, and

WHEREAS, The practice of radiology should not be hindered by the policies on certain Blue Shield prepayment plans, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association adopt a uniform policy for all contracts issued by Ohio Medical Indemnity, Inc., which will provide for payment to the physician when services can be rendered by him in the office and billed to the patient for payment under Blue Shield contracts,

#### RESOLUTION NO. 11

Amendments to the Ohio Medical Practice Act

(By the Academy of Medicine of Cincinnati)

WHEREAS, Section 4731.51 of the Ohio Revised Code authorizes podiatrists to treat ailments of hand or foot, and

WHEREAS, Podiatrists are not trained and qualified to perform hand surgery, and

WHEREAS, Other sections of the Medical Practice Act should be amended, and

WHEREAS, Efforts to obtain injunctive relief have been defeated by the General Assembly, and

WHEREAS, Enforcement of the law against second of-

fenders who violate the Medical Practice Act have little regard for the subsequent convictions and fines imposed are not severe enough to establish respect for enforcement of said Medical Practice Act, and

WHEREAS, Illegal practices have caused irreparable damage to the public through quackery, and

WHEREAS, Limited practitioners licensed by the Ohio State Medical Board have not rightfully used their licenses in certain cases, and

WHEREAS, The effective enforcement of the Medical Practice Act is deterred because offices of limited practitioners are not open for regular inspection, and

WHEREAS, The Ohio State Medical Board is not given the necessary authority to effectively enforce its rules and laws against undesirable practitioners both limited and general, and

WHEREAS, The Attorney General of the State of Ohio has refused to defend inspectors when suits are filed against them personally, for enforcement of law within the scope of their authority to the making appropriate arrests while in the performance of their duties; therefore,

BE IT RESOLVED, That Section 4731.51 of the Ohio Revised Code be revised by deleting the words "chiroprody" and "hand," and

BE IT FURTHER RESOLVED, That the penalty section of 4731.99, Ohio Revised Code, provide severe penalties for second and subsequent offenders, and

BE IT FURTHER RESOLVED, That all licenses of limited practitioners expire on an annual basis and said licenses be subject to renewal; and

BE IT FURTHER RESOLVED, That the Ohio State Medical Board be given the necessary authority to enforce its rules against undesirable practitioners, including the right of inspection during reasonable hours, and

BE IT FURTHER RESOLVED, That the medical inspectors of the State of Ohio receive the protection of the State through representation by the Attorney General for the State of Ohio.

#### RESOLUTION NO. 12

Review of Fee Schedules for Agencies of the State of Ohio

(By the Academy of Medicine of Cincinnati)

WHEREAS, It has been represented in a reference committee at a previous meeting of the House of Delegates that periodic reviews of fee schedules for agencies of the State of Ohio have been regularly conducted, and

WHEREAS, Specialty organizations in the State and individual members of the Ohio State Medical Association have made frequent inquiries about reviews of the schedules of State agencies, and

WHEREAS, Delegates representing the Academy of Medicine of Cincinnati agreed to withdraw a previous resolution which purported to adopt a regular review of fee schedules, and

WHEREAS, There has been considerable delay in reviewing the schedules of agencies of the State of Ohio; therefore,

BE IT RESOLVED, That the House of Delegates adopt as a policy a routine periodic review (preferably every two years) of fee schedules of agencies of the State of Ohio, including the Division of Aid for the Aged, Welfare and Workmen's Compensation, and

BE IT FURTHER RESOLVED, That the revised schedules be presented to the appropriate agencies of the State of Ohio.

#### RESOLUTION NO. 13

To Authorize Physicians and Pharmacists to Prescribe and Provide Contraceptive Information and Materials

(By the Academy of Medicine of Cleveland)

WHEREAS, Physicians at times recommend the limitation of family size or the interval spacing of conception and pregnancy for the life and health of the mother, and

WHEREAS, Methods of such control are now available which assure family spacing with great safety, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct the Council and Executive Staff to urge the Ohio Legislature to amend



the Ohio Revised Code so as to separate regulations concerning contraceptive information and materials from the laws on obscenity, and to authorize and permit physicians and pharmacists in their legitimate enterprise to sell, give away, and keep for sale or gratuitous distribution drugs, nostrums, and appliances for preventing conception.

#### RESOLUTION NO. 14

To Permit City, County and State Health Departments to  
Suggest, Prescribe or Make Available Information and  
Materials for Contraception

(By the Academy of Medicine of Cleveland)

WHEREAS, Unchecked human reproduction already poses a grave threat to the health and welfare of society both in the United States and elsewhere, and

WHEREAS, Pregnancy sometimes can and does threaten the life and well-being of individual mothers, and

WHEREAS, Numerous and undesired pregnancies may result in deterioration of family life, a life of misery for unwanted dependent children, and intensification of social problems of disease, delinquency, and crime, and

WHEREAS, There exist safe means of a variety sufficient to be compatible with varying religious beliefs and mores, therefore

BE IT RESOLVED, That the Ohio State Medical Association does hereby urge such revision of Ohio laws, statutes, and departmental directives as may be necessary to permit and require physicians or public health officers employed by the Department of Health of the State of Ohio and of departments of health of counties, cities, or districts within the State of Ohio to make available information or materials for family planning and contraception consistent with the religious beliefs and mores of the patient, upon request by the patient or upon the initiative of the physician or health officer when in such officers' professional opinion such information is necessary for the health and welfare of the patient, or of the community, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association hereby urges component county medical societies to support such legislation and policy directive as will ensure comparable action by health authorities within each county.

#### RESOLUTION NO. 15

Need for General Practitioners

(By Mahoning County Medical Society)

WHEREAS, The number of communities lacking the services of a physician has been increasing each year; and

WHEREAS, The supply of physicians in this country has become a matter of concern to many people; and

WHEREAS, There may be a relative oversupply of certain specialists in some of our larger cities; and

WHEREAS, There is a growing need for more general or family physicians; and

WHEREAS, Many young physicians choose a specialty while in medical school before really having had an opportunity to survey the entire field of medicine and before ascertaining that another field might be more interesting and offer greater satisfaction, thereby making a better practitioner of the specialty of his more mature choice; and

WHEREAS, The teaching of interns and nurses could be more effectively performed by residents of experience and maturity; and

WHEREAS, The medical profession should do all within its power to meet the demand of the general public; therefore be it

RESOLVED, That the American Medical Association strongly urge the Joint Commission on Accreditation of Hospitals to encourage applicants for residency training in the various specialties to have several years of general practice before undertaking specialty training.

#### RESOLUTION NO. 16

OSMA Dues Exemption for Members  
70 Years of Age and Over

(By The Council, Ohio State Medical Association)

WHEREAS, At the 1964 Annual Meeting of this Association the House of Delegates adopted substitute resolu-

tion No. 5 directing The Council to draft an appropriate amendment to the Bylaws of the Association so as to provide for the exemption from dues and assessments of members who are seventy (70) years of age or over, and

WHEREAS, The second paragraph of the present Section 1 of Chapter 2 of the Bylaws provides exemption from dues and assessments only to those doctors of medicine who have retired from "active practice because of age or disability," said present paragraph 2 reading as follows:

"Provided, however, that a doctor of medicine who is not engaged in active practice because of age or disability and who was a member in good standing of this Association at the time of his retirement from active practice shall be exempt from the payment of dues and assessments in this Association, provided he requests such exemption and such request is approved in writing by the secretary-treasurer of his component society," and

WHEREAS, It is deemed necessary and advisable to amend the second paragraph of Section 1 of Chapter 2 in order to provide for the exemption from Association dues of those members who are seventy (70) years of age or over;

NOW, THEREFORE, BE IT RESOLVED, That the second paragraph of Section 1 of Chapter 2 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended to read as follows:

Provided, however, that any doctor of medicine (a) who has been engaged in active practice in Ohio for at least ten (10) consecutive years, and has attained the age of seventy (70) years or more, and has been a member in good standing of this Association for at least ten (10) consecutive years, or (b) who has ceased or shall have ceased to be engaged in active practice because of age or disability, and who is a member in good standing of this Association, may request, in writing, exemption from the payment of dues and assessments in this Association; and upon the approval, in writing, of such request by the secretary of the component society of which such doctor of medicine is then a member in good standing and the filing of such written approval with the Executive Secretary of this Association, such doctor of medicine shall be exempt from the payment of all dues and assessments accruing on or after the first day of January next succeeding the date of the filing of such written approval with the Executive Secretary of this Association.

#### RESOLUTION NO. 17

Re: Osteopathic Physicians

(By the Portage County Medical Society)

WHEREAS, The American Medical Association has seen fit to make ethical the association between its members and those osteopaths who practice "Scientific Medicine," and

WHEREAS, The Ohio State Medical Association has granted the right to County Societies to accept as associate members those osteopaths who do practice "Scientific Medicine," and

WHEREAS, The phrase "Scientific Medicine" fails to clearly classify an individual osteopath, future attempts to evaluate an osteopathic physician will remain difficult because his own training programs have not received accreditation by the appropriate committees of the American Medical Association, and

WHEREAS, If it were possible for the graduate of an osteopathic school to receive internship and residency training in an AMA approved program, he could then be accepted for his demonstrated abilities to practice scientific medicine. Be it therefore

RESOLVED, That the Ohio Delegation to the American Medical Association enter and support a resolution to make possible intern and residency training for the properly qualified osteopathic physician in existing AMA approved hospital programs.

## RESOLUTION NO. 18

### Nominating Committee Procedures and Nominations For the Office of President-Elect

WHEREAS, At the 1964 Annual Meeting of this Association, the House of Delegates adopted recommendations of the Nominating Committee asking that the Council of the Ohio State Medical Association make a study of the provisions of Chapter 5 of the Bylaws with a view of recommending such changes therein as may be necessary or advisable in order to define clearly the scope, function and authority of the Committee on Nominations and to prescribe an orderly procedure for the carrying out of the committee's assignments and responsibilities, and

WHEREAS, At the same meeting the House of Delegates adopted Amended Resolution No. 3, directing the President of the Ohio State Medical Association to appoint a committee to study a method or methods of announcing a nominee or nominees for the office of President-Elect prior to the time of the Annual Meeting, and

WHEREAS, The Council and the committee were instructed to report their findings at the Next Annual Meeting of the Ohio State Medical Association, and

WHEREAS, Both matters were assigned to an Ad Hoc Committee on Revisions of the OSMA Constitution and By-Laws for implementation, and

WHEREAS, Such committee has studied the instructions of the House of Delegates and has developed suggested amendments to carry out the wishes of the House, therefore

BE IT RESOLVED, That the following amended Section 1 of Chapter 5 of the Bylaws of the Ohio State Medical Association be submitted for the consideration of the House of Delegates:

## CHAPTER 5

### NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. On the first day of the annual meeting the House of Delegates shall elect a Committee on Nominations consisting of one delegate from each councilor district. The chairmanship of the Nominating Committee shall be rotated in numerical order annually among the Councilor district representatives on the committee. The Committee on Nominations shall report to the House of Delegates a ticket containing the name of

one or more members for each of the offices to be filled at that annual meeting except that of President-Elect. Prior to selecting a ticket the Committee shall permit the opportunity for hearings which will be open to all members in good standing of the Ohio State Medical Association. Any member in good standing may have the opportunity to appear before the Committee in behalf of a proposed candidate. In addition, the Committee may request an interview concerning the proposed candidate's qualifications, with the candidate, or with any other member. Each nominee must have a majority vote in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the district for which he is nominated. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates, provided however that only those candidates may be nominated whose names have been filed with the Executive Secretary at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon filing of such candidate name, the Executive Secretary, if such candidate is eligible for election, shall prepare and transmit this information to each member of the House of Delegates. No candidate may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at such meeting. The Executive Secretary shall cause to be published in The Journal in advance of such meeting of the House of Delegates biographical information on all eligible candidates meeting the requirements of filing and transmittal.

(NOTE: Underlining indicates new material)

**Annual Meeting Telephone Service.** The Academy of Medicine of Columbus and Franklin County will maintain an information booth and telephone service for the benefit of physicians attending the 1965 OSMA Annual Meeting in Columbus, May 9-14. The booth will be set up in the Veterans Memorial Building near the Registration Desk during times that programs and events are scheduled in the building. A special telephone number has been reserved for this booth. It is 224-3664.

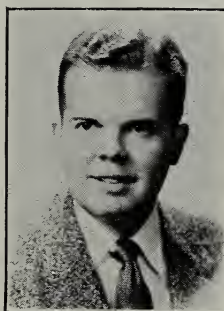


# Guest Speakers at Annual Meeting Add Much to Varied Program

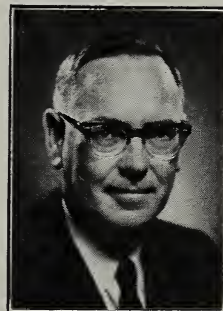
THE theme, Medicine and the Whole Man, is well chosen for the 1965 OSMA Annual Meeting scheduled in Columbus, May 9-14, since speakers and topics for discussion will cover nearly every phase of practice. Planners of the program have reached far and wide to bring to this State speakers who are qualified to discuss topics of vital importance to physicians in everyday practice. More than 20 out-of-state guest speakers have accepted invitations to appear on the program. In addition, many Ohio physicians from all parts of the State will present lectures, serve on panels or otherwise contribute to an all-round meeting. Following are names and pictures of out-of-state guest speakers with information on topics to be presented and times of appearance. Also included is other information on Annual Meeting features.

Daniel Bergsagel, M. D., Toronto, Canada, chief of medicine, Ontario Cancer Institute, will speak on Wednesday morning during the General Session sponsored by the American Cancer Society, Ohio Division, on the subject, "Leukemia," and will participate in a panel discussion on cancer at the same session.

Robert E. Carroll, M. D., New York City; associate clinical professor of orthopaedic surgery, Columbia University College of Physicians and Surgeons, and chief of hand service for New York Orthopaedic Hospital, will speak on Tuesday afternoon during the General Session program sponsored by the Ohio Committee on Trauma of the American College of Surgeons, on the topic, "Fractures Involving the Hand, and Hand Injuries."



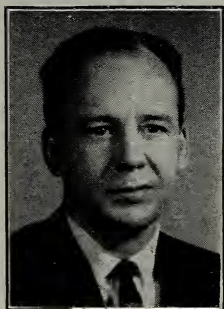
Robert S. Daniels, M. D.  
Chicago, Ill.



John Donnelly, M. D.  
Hartford, Conn.

Robert S. Daniels, M. D., Chicago, associate professor and acting chairman, Department of Psychiatry, University of Chicago School of Medicine, will be luncheon speaker for the session sponsored by the Section on Psychiatry and the Ohio Psychiatric Association. His topic will be "Community Psychiatry — A New Profession, A Developing Sub-Specialty or Effective Clinical Psychiatry." (The luncheon will be in the Columbus Plaza Hotel.)

John Donnelly, M. D., Hartford, Conn., medical director, Institute of Living, will speak on Friday morning during the session sponsored by the Section on Psychiatry and Neurology and the Ohio Psychiatric



Daniel Bergsagel, M. D.  
Toronto, Canada



Robert E. Carroll, M. D.  
New York City

## Specialty Section and Specialty Society Programs

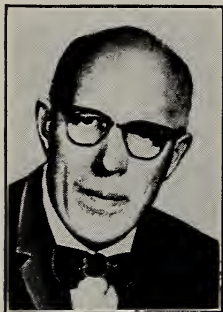
Specialty Sections and Specialty Societies have combined to present joint sessions. Programs are scheduled in many of the specialty fields, but any physician is welcome to attend any of these sessions. Check the program in the March issue of *The Journal* for details as to time and place, speakers, topics and special features.

Outstanding features of the Annual Meeting program are the Specialty Section and Specialty Society programs. In many instances

Association, on the topic, "Treatment of Character Disorders."

**René Jules Dubos, Ph. D.,** New York City, will speak on Thursday afternoon during the Ohio Health Commissioners Institute on the topic, "Latency, Activation and Control of Infectious Diseases."

**Harry Grabstald, M. D.,** New York City, associate attending surgeon, Urologic Service, Memorial Sloan-Kettering Cancer Center, will speak during the General Session on Wednesday morning sponsored by the American Cancer Society, Ohio Division, on the topic, "Cancer of the Urinary Bladder," and will participate in a panel discussion on cancer during the same session.



**René Jules Dubos, Ph. D.**  
New York City



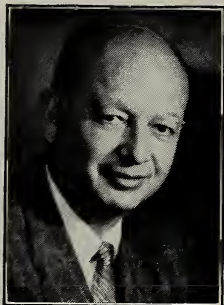
**Harry Grabstald, M. D.**  
New York City

**Roy R. Grinker, Sr., M. D.,** Chicago, director of the Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital Medical Center, will be the after-dinner speaker for the Thursday evening meeting of the Ohio Psychiatric Association and the Central Ohio Neuropsychiatric Society. His topic will be "Depression and Normality; Psychosomatic Aspects."

**Howard P. House, M. D.,** Los Angeles, Calif., clinical professor of otology, University of Southern California School of Medicine, and director of the Los Angeles Foundation of Otology, will speak on Thursday afternoon in the session sponsored by the Section on Ear, Nose and Throat, and the Ohio Ear, Nose and Throat Society, on the topic, "Clinical Facets of Inner Ear Problems." At a Thursday



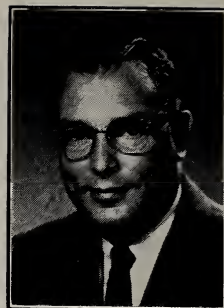
**Roy R. Grinker, Sr., M. D.**  
Chicago, Ill.



**Howard P. House, M. D.**  
Los Angeles, Calif.



**Jay Jacoby, M. D.**  
Milwaukee, Wis.

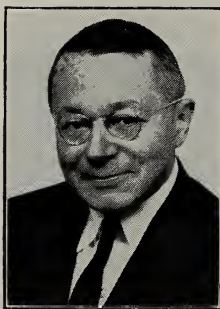


**Richard H. Jesse, M. D.**  
Houston, Texas

evening dinner meeting of the Ohio Ear, Nose and Throat Society in the Columbus Plaza Hotel, Dr. House will speak on the topic, "Otology in Orbit."

**Jay Jacoby, M. D.,** Milwaukee, Wisconsin, professor of anesthesiology, Marquette University School of Medicine, will speak on Thursday afternoon during the session jointly sponsored by the Section on Anesthesiology and the Section on General Practice, on the topic, "Expanding Role of Anesthesiology." He also will participate in a panel discussion on "Pain Management."

**Richard H. Jesse, M. D.,** Houston, Texas, associate surgeon, Head and Neck Service, M. D. Anderson Hospital and Tumor Institute, University of Texas Medical Center, will speak during the General Session sponsored by the American Cancer Society, Ohio Division, on Wednesday morning, on the topic, "Chemotherapy of Solid Tumors in Relation to the Head and Neck," and will participate in a general panel discussion during the same session.



**Averill Liebow, M. D.**  
New Haven, Conn.



**Robert J. Lukes, M. D.**  
Los Angeles, Calif.

**Averill Liebow, M. D.,** New Haven, Conn., professor of pathology, Yale University College of Medicine, will speak on Thursday afternoon during the session sponsored by the Ohio Chapter, American College of Chest Physicians, Section on Radiology. He will participate in a panel discussion, entitled "A Panorama of Chest Disease," presenting the subject from the standpoint of Pathology.

**Robert J. Lukes, M. D.,** Los Angeles, Calif., professor, Department of Pathology, University of

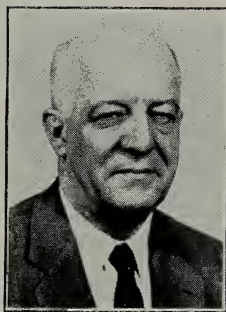


Southern California School of Medicine, will speak twice on Friday afternoon in the session jointly sponsored by the Section on Pathology and the Ohio Society of Pathologists. His first topic will be "A New Approach to the Pathologic Evaluation of Hodgkin's Disease." He also will preside at a "Slide Seminar on Lymph Node Biopsy," as part of the same program.

Henry D. McIntosh, M. D., Durham, North Carolina, professor, Department of Medicine, and director of Cardiovascular Laboratory, Duke University School of Medicine, will speak on Wednesday afternoon in the session sponsored by the Section on Internal Medicine of the OSMA and the Ohio Society of Internal Medicine, on the topic, "Cardioversion."



Henry D. McIntosh, M. D.  
Durham, N. C.



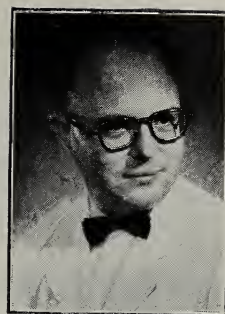
Gordon P. McNeer, M. D.  
New York City

Gordon P. McNeer, M. D., New York City, attending surgeon and chief of the Gastric and Mixed Tumor Service, Memorial Sloan-Kettering Cancer Center, will speak before the General Session sponsored by the American Cancer Society, Ohio Division, on Wednesday morning, on the topic, "Cancer of the Stomach and Distal Esophagus," and will participate in a panel discussion on cancer at the same session.

Thomas K. Oliver, Jr., M. D., Seattle, Wash., associate professor, Department of Pediatrics, University of Washington School of Medicine, will speak twice during the session on Friday afternoon sponsored by the Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics. His first topic will be "Respiratory Distress," and his second, "Indications for Exchange Transfusions in Hyperbilirubinemia."



Thomas K. Oliver, Jr. M. D.  
Seattle, Wash.

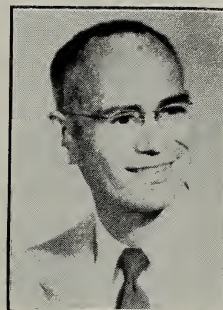


L. F. Peltier, M. D., Ph. D.  
Kansas City, Kan.

Leonard F. Peltier, M. D., Ph. D., Kansas City, Kansas, professor of surgery and head of Section of Orthopaedic Surgery, University of Kansas School of Medicine, will speak on Tuesday afternoon during the General Session program sponsored by the Ohio Committee on Trauma of the American College of Surgeons on the topic, "Newer Concepts in the Treatment of Fractures of the Spine."



Donald L. Rose, M. D.  
Kansas City, Kan.



George G. Rowe, M. D.  
Madison, Wis.

George G. Rowe, M. D., Madison, Wisconsin, professor of medicine, Cardiovascular Section, University of Wisconsin Medical School, will speak during the General Session on Thursday morning sponsored by the Ohio State Heart Association, on the topic, "Coronary Vasodilators."

Donald L. Rose, M. D., Kansas City, Kansas, professor, Department of Physical Medicine, University of Kansas School of Medicine, will speak on Wednesday afternoon in the session sponsored by the

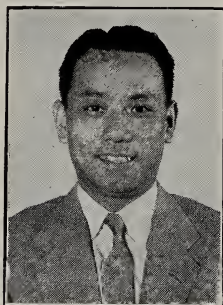
### Scientific, Educational and Technical Exhibits

The Exhibit Floor of the Veterans Memorial Building will house two outstanding features of the Annual Meeting—the Scientific and Educational Exhibits and the Technical Exhibits. Ample recesses are allowed throughout the program to provide time for visits to the Exhibit Floor. Sponsors of Scientific and Educational Exhibits will be on hand to discuss their projects. Detail men will be in the Technical Exhibits to discuss their various products and services. Refer to the March issue of *The Journal* for lists of exhibitors.

Section on Physical Medicine and Rehabilitation and the Ohio Society of Physical Medicine and Rehabilitation. He will discuss "Etiology" in a program on "Management of the Painful Shoulder," and the "Shoulder-Hand Syndrome," during a panel presentation. At a dinner meeting of the Ohio Society of Physical Medicine and Rehabilitation in the Christopher Inn, Dr. Rose will speak on the topic, "Who Is a Psychiatrist?"



William H. Spencer, M. D.  
San Francisco, Calif.



Paul N. Yu, M. D.  
Rochester, N. Y.

William H. Spencer, M. D., San Francisco, Calif., assistant clinical professor of ophthalmology, University of California School of Medicine, will speak on Thursday afternoon during the session sponsored by the Section on Ophthalmology and the Ohio Ophthalmological Society, on the topic "Interesting Causes of Unilateral Exophthalmos in Children."

Paul N. Yu, M. D., Rochester, N. Y., professor, Department of Medicine, and head of the Cardiopulmonary Unit, School of Medicine and Dentistry, University of Rochester, will deliver the Rudolph Allen Gerlinger Memorial Lecture of the Northwestern Ohio Heart Association, during the General Session on Thursday morning sponsored by the Ohio State Heart Association. His topic will be "Rationale and Proper Use of Digitalis."

### Other Features:

Meetings of the House of Delegates

Medical Motion Pictures

Special Programs on Heart; Cancer

General Sessions

OSU College of Medicine Faculty  
On "What I Do About — —"

Luncheons, Social Hours, Dinners  
By Special Groups

Woman's Auxiliary Meetings

Refer to March Issue of *The Journal*  
For Details of the Program

## The President's Reception

6:00 to 8:00 p. m.

Wednesday, May 12, 1965

Venus-Mars-Jupiter-Saturn Rooms,  
Second Floor  
Columbus Plaza Hotel



Social highlight of the 1965 Annual Meeting.

A congenial get-together where members, their ladies and guests may gather for refreshments, dancing and the atmosphere of a social period.

NO SPEECHES — NO FORMAL PROGRAM  
DRESS: OPTIONAL



Hors D'Oeuvres

will be served by the Association

Cash Bar Will Be Open



Following adjournment of the reception at 8:00 o'clock, members and guests will have ample time to dine at the place of their choosing.



Dancing to the accompaniment  
of  
CHUCK SELBY AND HIS ORCHESTRA



## Leading Downtown Columbus Hotels and Prevailing Rates

### COLUMBUS PLAZA HOTEL (Headquarters)

50 N. Third Street

Singles .....	\$11.50 - 15.50
Twins .....	14.00 - 19.00

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W. Broad & N. High Streets

Singles .....	\$ 7.50 - 14.50
Doubles .....	12.00 - 18.00
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### NEIL HOUSE

41 So. High Street

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### HOTEL SOUTHERN

So. High & E. Main Streets

Singles .....	\$ 8.00 - 8.50
Doubles .....	11.00 - 11.50
Twins .....	11.50 - 13.00

### CHRISTOPHER INN

300 E. Broad Street

Singles .....	\$10.00 - 12.50
Doubles .....	13.00 - 15.00
Twins .....	17.00 - 18.00

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31 W. Spring Street

Singles .....	\$ 7.50 - 13.00
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overnight parking of automobile.*

If you plan to share a room, please indicate name  
of roommate so the hotel may avoid duplicate  
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## 1965 Annual Meeting Ohio State Medical Association

**COLUMBUS**

**MAY 9 - 14**

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(NAME OF HOTEL)

\_\_\_\_\_  
Columbus, Ohio

(ADDRESS)

Please reserve the following accommoda-  
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Medical Association Annual Meeting,  
May 9 - 14 (or for period indicated)

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☐ Double Room

☐ Twin Room

Other accommodations \_\_\_\_\_

Price range \_\_\_\_\_

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# Comments on Preceptorship...

## Cincinnati Senior Medical Student Gives Views on His Part in Program Sponsored by the Association

SOMETHING NEW was added to the OSMA Student Lecture programs for medical students at the University of Cincinnati and the Ohio State University. At each school a former preceptee was asked to give his impression of the preceptorship program. The following presentation was given by Mr. Fred Rosewater, senior medical student, at the University of Cincinnati lectures.

\* \* \*

I have been asked to tell you about my impression of a preceptorship program I participated in last summer. Before going further into some of the actual details, I would like to say quite categorically that I would strongly recommend this kind of experience to any medical student.

I suppose I should start off first by telling you a little about myself, so you can understand better what my interests and motivations were in this case. I am from Cleveland originally and have always lived in larger cities. Prior to this summer, I never spent any time in a small town. At the time I participated in the preceptorship program and also presently, I have been interested in going into one of the specialties—probably either Internal Medicine or Pediatrics—and have never particularly been interested in entering general practice.

### Why This Interest?

One of the questions which I suppose might be intelligently interposed here, is why was I interested in this program in the first place. Aside from just plain old curiosity about what the practice of medicine is like away from the University, I also had built up some pressing questions about just what kind of life a doctor leads away from the office—that is with his wife and family, how a physician manages the business side of his practice, and just what kind of relationship a doctor has with patients in their homes and after long acquaintanceships, as contrasted with the rather superficial and somewhat misleading kind of relationship we see between doctor and patient in our clinic population. For these reasons I decided that the preceptorship was certainly worth a few weeks of my time, especially when compared with the many months devoted to learning so much of the factual information of medicine in the previous three years of medical school, I might add.

After applying for the preceptorship I was informed in the early summer that I would go to Convoy, Ohio—a small town, population 1,000 up in Northeastern, Ohio—to spend 1½ weeks with Dr. Alfred Diller. When I finally arrived in Convoy in late summer—and I might add at this point that Convoy, Ohio, a town that doesn't possess a traffic light and is more like an intersection than a town—is an exceedingly easy town to miss. But when I finally arrived, I was greeted by Dr. and Mrs. Diller and their five children—four boys and a little girl.

I was soon to find out that the size of a town bore no simple relation to the kind of medicine that is practiced there—both in terms of quality and variety of things seen and done.

### Introduction to Practice

The routine I followed for the next ten days was that of accompanying Dr. Diller as he went about his usual procedures. We started the day off by going to the Van Wert County Hospital where we made rounds on Dr. Diller's patients, possibly assisted in surgery if any of his patients were scheduled and came back in the afternoon to see his various office patients together.

Early in the week, I met Dr. Norman L. Marxen, a board surgeon, who does most of the surgery in Van Wert County, of which Convoy is a part. Although I am not particularly interested in going into surgery, I had developed an interest and a great respect for the surgical art during an externship on a surgical ward in a Cleveland Hospital the previous summer. During this period I had availed myself of the opportunity of learning to tie surgical knots and although tying thousands of knots to bed posts and whatever fingers I could borrow, I had never had the opportunity of doing much tying in actual surgery. When I started working with Dr. Marxen, he allowed me the opportunity of trying out my newly-learned skill in surgery.

For the following ten days I had the unique experience as a junior medical student of working as a first assistant with this remarkably patient surgeon. I might add here, as I am sure is well known, that this is a privilege which is usually given to residents and occasionally to interns. I assisted in quite a few major and some minor operations, just to mention a few—a cholecystectomy, a couple of hip pinnings,








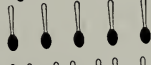

# Recommended Dosage of Lomotil Liquid to Control Diarrhea

*File ✓  
Diarrhea*

## LOMOTIL®

### Age

### INITIAL LOMOTIL LIQUID DOSAGE\*

3-6 mo. ....	1/2 tsp. t.i.d. (3 mg.)	
6-12 mo. ....	1/2 tsp. q.i.d. (4 mg.)	
1-2 yr. ....	1/2 tsp. 5 times daily (5 mg.)	
2-5 yr. ....	1 tsp. t.i.d. (6 mg.)	
5-8 yr. ....	1 tsp. q.i.d. (8 mg.)	
8-12 yr. ....	1 tsp. 5 times daily (10 mg.)	
Adult .....	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)	

\*Based on 4 cc. per average teaspoonful.

Note: After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

## LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride ..... 2.5 mg.  
(Warning: May be habit forming)

atropine sulfate ..... 0.025 mg.

### Precautions

Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

### Cautions and Side Effects

Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**SEARLE**

Research in the Service of Medicine

a hysterectomy, a hernia repair, an amputation, a c-section, a few varicose vein strippings, etc.

### Seeing the Patient

The afternoons I spent in Dr. Diller's office were usually also very interesting. We would see patients together, during which time I could observe how an expert does a quick, yet efficient history and physical exam and how he conducted himself with each patient, skillfully changing his approach and his relationship to patients, as the various personalities, sexes, and ages rapidly changed from one room to the next. I observed how he talked cordially and honestly to each patient, and conversely saw the great respect his patients paid him in return and how he had become a very integral and necessary part in the lives of these people. The expectant mother, the child in pain, the unsophisticated pubescent female, the lonely and maybe apprehensive geriatric patient all looked to him for advice and support. Surely for the first time in medical school the doctor-patient relationship came to be more than an overly used phrase; the Art of Medicine had become vividly alive and real.

After seeing patients together we would discuss the diagnosis and treatment. I would ask why he asked certain questions, or how he arrived at his conclusions, or possibly what tests he would and would not run, taking all the factors of the expense, the medical indications, etc., into account. These and many other questions he answered so adeptly made the ten-day period become a meaningful learning experience.

Dr. Diller spent a good part of one afternoon going over how he bills patients, keeps his medical records straight, pays for the overhead, and generally manages the business side of his practice.

### The Laboratory of Life

When thinking back over the medical problems that I saw with Dr. Diller, I realized that I saw many things I had either never seen before when in Cincinnati General Hospital or had only seen occasionally. For example I saw cases of diabetes insipidus, Addison's disease, muscular dystrophy, Parkinson's disease, bronchiectasis, and a minor epidemic of 5 to 10 cases of a viral pharyngitis.

Dr. Diller also left me with many interesting little tidbits which I think I will always remember. For example, I learned that when you have farmers as patients you can often be expected to be paid every six months or so, or when the harvest comes in, or that business completely shuts down during fair week and you might as well take your vacation then, or that when parents bring in an injured child and the father is a big strapping "six-footer," that you don't worry about the mother, but you had better keep your eye on the father all the time and have

the smelling salts ready — this last truism, incidentally was dramatically illustrated to me.

In conclusion I would like to say once again that my impression of the preceptorship program is that it is a unique experience for any medical student. Surely the opportunities of learning medicine firsthand from men who are interested in the practical aspects of medicine, of seeing constant examples of the techniques by which the experienced physician practices the Art of Medicine, of being introduced to different people and different ideas, of learning something about the business side of medicine, and of seeing a great variety of different medical problems in a short period of time are very valuable ones. I think I might also mention as a final note, here, that having talked to the other fellows who participated in this program last summer, that they all agree it was truly a worthwhile experience.

## Ohio State Heart Association May Program Features

The Ohio State Heart Association will hold its four-day annual meeting in Columbus, May 10-13, including the scientific session to be presented on Thursday morning, May 13, at the Veterans Memorial Building as a feature of the Ohio State Medical Association's Annual Meeting program.

Dr. Irving S. Wright, professor of clinical medicine, Cornell University, and past-president of the American Heart Association, will speak Wednesday, May 12, following the annual luncheon in the Pick-Fort Hayes Hotel. He will discuss the President's Commission Report on Heart Disease, Cancer, and Stroke.

Other highlights of the Heart Association's annual meeting include Monday and Tuesday sessions for staff members of local heart chapters, and Wednesday panel discussions for board members and representative delegates to the state association; also board of trustees' dinner, annual membership meeting, and election of officers.

Dr. Paul N. Nu, professor of medicine and head of the cardiopulmonary unit, University of Rochester, will be another featured speaker at the Heart Association meeting.

Dr. Yu will deliver the annual Rudolph Allen Gerlinger Memorial Lecture on Thursday, May 13, as part of the scientific program in the Veterans Memorial Building, on the subject, "Rationale and Proper Use of Digitalis."

Other speakers and their subjects for the scientific program are Dr. Phillip Horowitz, Toledo, "Management of Shock of Acute Myocardial Infarction"; Dr. George G. Rowe, professor of medicine, University of Wisconsin, "Coronary Vasodilators"; Dr. Joseph M. Ryan, professor of medicine, Ohio State University, "Digitalis Toxicity." Dr. George Morrice, Jr., Columbus, chairman of the program committee, will preside at the scientific session.





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# Comments on Current Economic, Social And Professional Problems

## DOCTORS COMPLIMENTED FOR PART IN RELIEF FUND SAVINGS

Physicians of the Butler County area received a pat on the back from the local welfare director, a compliment that is worthy of greater distribution. Following is an excerpt from a Butler County newspaper, the *Middletown Journal*, on this subject:

"Doctors played a key role in helping to reduce Butler County general relief fund expenditures during the first half of 1964, Warren Harding, county welfare director, noted today in his six months report.

"Physicians have concentrated on providing more home and outpatient care to indigents, resulting in lower hospital and medical expenses for the welfare department, he said.

"We have received excellent cooperation from doctors in reducing the number of hospitalized cases."

"Relief Fund expenditures this year for six months totaled \$129,409.66 compared with a figure of \$282,285.15 in a corresponding part of 1963.

"Efforts by the physicians is reflected in a reduction of medical and hospital costs from \$130,328 last year to \$63,398 in 1964, a drop of \$66,930 or more than 50 per cent."

## JOURNALISM TEACHER SEES AMERICA AS "GREATEST" SOCIETY

"I'm getting tired of politicians, professors and columnists who keep downgrading America and the system that made us so free and strong.

"The big news about this country is not that we have so much poverty and prejudice—but that we have so little compared to other nations.

"By any honest standard America has The Greatest Society yet known to man. It offers the greatest good to the greatest number—more freedom, opportunity, food, clothing, shelter. Millions are trying to get in. Few, if any, want out.

"Today, when powerful enemies boast they will destroy us, it's time to stop this public breast-beating about our relatively few faults. Though we're still far from perfect, we are the BEST YET and we'd better be proud and have faith.

"Belief breeds strength, liberty and self-respect. Doubt erodes like cancer and leads to slavery and death.

"Progress? Yes! We have made more than any other country and must continue to advance in all

sensible directions. But let's stop comparing America with Utopia and start comparing her to other earthly societies of imperfect human beings. On such an honest scale America looks very good."

Nationwide attention has been called to the foregoing comment made by Walter W. Seifert, associate professor in the School of Journalism at Ohio State University, and a man who gave up a successful business career to teach. In our opinion, others would do well to express themselves, as Mr. Seifert indicates in the following additional comments:

"Like many others, I am deeply concerned for the future of this nation, which has been very good to me and my family. Certain trends in recent years seem to threaten the land I love. I believe each American who holds strong views should express them before the court of public opinion. That's why I wrote and published *The Greatest Society*."

## MORTALITY STATISTICS NEED BASIS FOR COMPARISON

Much has been written on life expectancy in certain European countries as compared with similar statistics in the United States, usually with the U.S. coming out second best. It is refreshing for a change to find an actuarial expert who views these reported differences with skepticism.

Admittedly mortality in the Soviet Union is higher than in the United States up to age 50, but after the mid-century mark the Soviet people claim they outlive Americans by a differential of as much as 15 to 20 per cent.

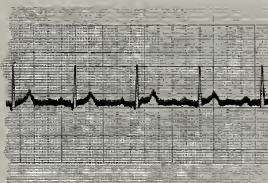
Robert J. Myers, actuarial chief in Washington at one of the Federal government offices, questions whether such figures are accurate and reliable and states in a prepared paper that the Soviet mortality rates at the older ages seem "unreasonably low."

Vital statistics in the United States are computed by one of the most highly developed methods known. Fairly uniform standards of reporting deaths prevail throughout the country. It would be interesting to know just how the European countries gather their material and how they report the resulting information.

Efforts are being made to standardize vital statistics reporting methods throughout the world. It will be interesting to read results and to again compare figures if such a standard is accomplished.



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# Woman's Auxiliary Annual Meeting...

THE WOMAN'S AUXILIARY to the Ohio State Medical Association will hold its 25th Annual Meeting in Columbus, concurrently with the Annual Meeting of the OSMA. Sessions are scheduled in the Christopher Inn, 300 East Broad Street in downtown Columbus, and all members are invited to participate in this silver anniversary meeting.

The schedule for Tuesday, May 11, calls for various committee meetings, a Board luncheon, and a pre-convention Board meeting. The general program begins on Wednesday morning and continues through Thursday.

Mrs. John Dickie, 2146 Shenandoah Road, Toledo, is the president of the State Auxiliary, and will preside at sessions. The President-Elect, Mrs. Herbert Van Epps, of Dover, will assume office as president at the close of the meeting.

Convention chairman is Mrs. H. I. Humphrey, 389 South Drexel Avenue, Columbus. Mrs. Joseph Tomaszewski, 2071 Ellington Road, Columbus, is co-chairman. Mrs. Richard Wehr will be chairman of Displays; Mrs. John Riepenhoff, of Finance; Mrs. Charles Pavay, of Guests; and Mrs. Merle Phillips, of Hospitality.

Mrs. O. M. Goodloe will be in charge of the Board luncheon; Mrs. Robert Rauch, of Pages; Mrs. Brooks Hurd, of Printing; and Mrs. Raymond Bethel, of Publicity. Heading the Registration committee will be Mrs. John Patrick Crawford; Roll Call, Mrs. Samuel Saslaw; Sponsors, Mrs. Rivington Fisher; and Tickets, Mrs. Floyd Beman.

Mrs. Joseph Moran, of Toledo, and members of the Lucas County Auxiliary will have charge of the Doctors' Day Luncheon. Members of the Tuscarawas County Auxiliary, headed by Mrs. Hammersley, will be hostesses at the Ladies' Day Luncheon.

## TUESDAY, MAY 11

- 10:00 a. m. Registration opens (remains open to 4:00 p. m.)
- 12:00 Noon Board Luncheon
- 1:30 p. m. Pre-Convention Board Meeting

## WEDNESDAY, MAY 12

- 8:30 a. m. Registration and Hospitality Room Open (remain open to 4:00 p. m.)
- 9:00 a. m. First Business Session  
Mrs. John Dickie, President, presiding
- 12:00 Noon Doctors' Day Luncheon  
Guest Speaker, Dr. Ever Curtis, Gloucester, Mass., Member of the AMA Speakers' Bureau

- 2:00 p. m. Reports of County Presidents
- 6:00 p. m. President's Reception of OSMA at the Columbus Plaza Hotel.

## THURSDAY, MAY 13

- 8:30 a. m. Registration opens (remains open to 4:00 p. m.)
- 9:00 a. m. Second Business Session  
Guest Speakers:  
Dr. Henry Crawford, Incoming President, OSMA  
Mrs. William Evans, Youngstown, President of the Woman's Auxiliary to the AMA  
Installation of Officers  
Inaugural Address — Mrs. Herbert Van Epps
- 12:00 Noon Ladies' Day Luncheon  
Speaker: Mrs. Jerrie Mock, Columbus Aviatrix, who recently made a record around-the-world flight
- 2:00 p. m. Workshop on Program Planning
- 4:30 p. m. Post-Convention Board Meeting

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# Ad Astra

**Edwin Adams Baker, M. D.,** Clyde; University of Buffalo School of Medicine, 1907; aged 80; died February 24; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician for some 60 years in the Clyde vicinity, Dr. Baker was active in numerous community affairs. Among affiliations, he was a member of the American Legion, the Kiwanis Club, Elks Lodge and several Masonic bodies. Survivors include his widow, a daughter, two sons and a brother.

**Esther DeYoe Brenneman, M. D.,** Toledo; University of Michigan Medical School, 1927; aged 69; died February 23; former member of the Ohio State Medical Association. A general practitioner, Dr. Brenneman had her office for many years in the Point Place area of Toledo. She was a member of the Episcopal Church. Surviving are a daughter and three sisters.

**Thomas Robert Curran, M. D.,** Columbus; Ohio State University College of Medicine, 1938; aged 52; died February 3; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician in Columbus, Dr. Curran was active in numerous medical organization functions; he was a past-president of the Academy of Medicine of Columbus; was a member of the OSMA Judicial and Professional Relations Committee, and was a former president of the Franklin County Academy of General Practice. During World War II, Dr. Curran served in the Army Medical Corps and attained the rank of lieutenant colonel. A member of the Catholic Church, he is survived by his widow, a daughter, a son, his mother and a sister.

**Edwin Lloyd Eakin, M. D.,** Los Angeles, Calif.; University of Cincinnati College of Medicine, 1961; aged 31; died February 9. A native of Fairfield County and outstanding student both at Pickerington High School and Kenyon College, Dr. Eakin was awarded the Ohio State Medical Association's Rural Medical Scholarship for the four years he was in the University of Cincinnati College of Medicine. At the time of death, he was associated with the Los Angeles County Hospital. Survivors include his parents and two sisters.

**Manning Gilbert Harnick, M. D.,** Coldwater; University of Toronto Faculty of Medicine, 1937; aged 51; died February 24; member of the Ohio

State Medical Association and the American Medical Association. Dr. Harnick was a native of Toronto, Canada, and served in the military service during World War II before he moved to Coldwater in 1947. Illness forced his retirement about a year ago. He was a member of the Catholic Church and the Holy Name Society; a member of the Elks Lodge, Lions Club and the VFW. Survivors include his widow, two children, two sisters and three brothers.

**Martin Lewis Helfrich, Sr., M. D.,** Galion; Ohio State University College of Medicine, 1916; aged 75; died January 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Helfrich's practice in Galion dated from World War I, during which he served overseas in the Army Medical Corps. In addition to his private practice, he served as city health commissioner and at one time as Crawford coroner. He was a member of the American Legion, several Masonic bodies, the Elks Lodge and the Lutheran Church. Surviving is his son, Dr. Martin L. Helfrich, Jr., of Bucyrus.

**Louis George Herrmann, M. D.,** Cincinnati; Washington University School of Medicine, 1924; aged 64; died February 17; member of the Ohio State Medical Association, American Medical Association, American Surgical Association, Western Surgical Association, International Society of Surgery, American Association for the Surgery of Trauma, American Society for Surgery of the Hand; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A practitioner in the field of vascular surgery in Cincinnati for many years, Dr. Herrmann was professor of surgery at the University of Cincinnati College of Medicine. Among his activities in medical organization work, Dr. Herrmann was a member for many years of the OSMA Committee on Scientific Work. Three survivors are physicians. His brother, Dr. George R. Herrmann, is professor of medicine at the University of Texas. One son, Dr. John B. Herrmann, is in Boston, and another, Dr. Kenneth L. Herrmann is in Atlanta, Georgia. Other survivors include his widow, a third son, a daughter and a sister.

**Ora Reed Jones, M. D.,** Cambridge; Ohio State University College of Medicine, 1927; aged 62; died February 2; member of the Ohio State Medical Association and the American Medical Association. Dr. Jones was a practicing physician and surgeon in Cambridge for a number of years, before he retired for reasons of health. A member of the Church of

Christ, he is survived by his widow, a daughter, a son, two sisters and four brothers.

**Wilson Schwab Kingsboro, M.D.,** Columbus; Vanderbilt University School of Medicine, 1941; aged 50; died February 20; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. A native of Shelby, Dr. Kingsboro practiced in that Richland County community before he moved to Columbus in 1958. A practitioner, specializing in anesthesiology, he also was deputy coroner for Franklin County. Dr. Kingsboro was a veteran of World War II, having served in the Medical Corps, and was a member of the Masonic Lodge. Surviving are his widow, a son, a daughter, his mother and a sister.

**Robert Lahm Marshall, M.D.,** Columbus; Ohio State University College of Medicine, 1942; aged 55; died February 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Dr. Marshall's practice in Columbus dated back to the end of World War II, during which he served in the Medical Corps. He was a member of the Presbyterian Church. Surviving are his widow, two sons, two daughters and two sisters.

**Ben Peskind, M.D.,** Cleveland; Western Reserve University School of Medicine, 1902; aged 84; died February 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Peskind practiced medicine for more than 50 years in Cleveland. For several years he had been living in retirement at the Hotel Commodore.

**William John Renner, M.D.,** Euclid; St. Louis University School of Medicine, 1939; aged 50; died February 15; member of the Ohio State Medical Association, the American Medical Association; diplomate of the American Board of Surgery; Fellow of the American College of Surgeons and of the International College of Surgeons. A practicing physician and surgeon in the Cleveland area, Dr. Renner formerly served five years with the Navy Medical Corps. He was a member of the Presbyterian Church. Survivors include his widow, four daughters, two sons, four brothers and three sisters.

**William Edgar Scaggs, M.D.,** Portsmouth; Ohio State University College of Medicine, 1927; aged 65; died February 21; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practicing physician and surgeon in Portsmouth for many years, Dr. Scaggs served during World War II in the Air Force Medical Corps.

**Frederick Smith Skeen, M.D.,** Batavia; University of Cincinnati College of Medicine, 1939; aged 52; died February 11; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Clermont County

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for about 25 years, Dr. Skeen was active in medical organization work and in community affairs. He was a past-president of the Clermont County Medical Society and a delegate of that Society to the OSMA House of Delegates. In the local area, he was former coroner, served as deputy sheriff and was for several years president of the Batavia School Board. He was a member of the Rotary Club and other local organizations. A veteran of World War II, he is survived by his widow, a daughter, a son and a sister.

**Torald Hermann Sollmann, M.D.,** Cleveland; Western Reserve University School of Medicine, 1896; aged 91; died February 11; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians. An outstanding physician, educator and author, Dr. Sollmann attained worldwide renown in the field of pharmacology and materia medica before his retirement in 1944. He is credited with writing the first textbook on pharmacology in English and had since written numerous texts and articles on the subject. For years he was a member and chairman of the Council on Pharmacy and Chemistry of the American Medical Association which issues the text *New and Nonofficial Remedies*. Head of the Department of Pharmacology at Western Reserve University for many years, he was later named professor emeritus of pharmacology and materia medica. He also held several committee appointments for the Association of American Medical Colleges and was a consultant of the U. S. Public Health Service. Dr. Sollmann was a member of the American Academy of Arts and Sciences. In 1934 he received the honorary doctor of science degree from Ohio State University and in 1941 his portrait was unveiled and hung in the WRU School of Medicine. His daughter survives.

**Walter S. Taylor, M.D.,** Albuquerque, New Mexico; Ohio State University College of Medicine, 1918; aged 71; died August 13, 1964; member of the Ohio State Medical Association and the American

Medical Association; diplomate of the American Board of Internal Medicine. A former practicing physician in Cleveland, Dr. Taylor later became associated with the Veterans Administration in Albuquerque before his retirement. His widow is among survivors.

**Ada May Willis, M.D.,** Wellston; Ohio State University College of Medicine, 1911; aged 84; died February 3. Dr. Willis retired about three years ago after practicing for more than 50 years, much of that time in the Wellston vicinity. She was a member of the Evangelical United Brethren Church. Two sisters survive.

**Irwin Edward Yoelson, M.D.,** Cleveland; Western Reserve University School of Medicine, 1919; aged 69; died February 28; member of the Ohio State Medical Association, the American Medical Association, the American College of Radiology and the Radiological Society of North America; diplomate of the American Board of Radiology. Dr. Yoelson's practice was in the field of radiology and for many years he was supervisor of the Radiology Department at Polyclinic Hospital. He was a member of the Temple. Survivors include his widow, two daughters, two brothers and two sisters.

**Nicholajs A. Zuments, M.D.,** Weston; University of Latvia Faculty of Medicine, 1942; aged 57; died February 5 in a railroad crossing accident; member of the Ohio State Medical Association and the American Medical Association. A native of Latvia and educated in that country, Dr. Zuments came to this country after World War II. He had been practicing in Weston since 1957. His widow and a daughter survive.

A recent announcement from the American College of Obstetricians and Gynecologists designates Dr. Donald J. Brugger, Canton, as a Fellow-elect; and Drs. John T. King and Teddy Swornowski, Akron, as Junior Fellows.

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References on request



# Activities of County Societies . . .

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### CLINTON

Dr. Harry Ezell, professor of gynecology at Ohio State University College of Medicine, spoke at a recent dinner meeting of the Clinton County Medical Society in Wilmington. The meeting was held in the Clinton County Memorial Hospital cafeteria.

Dr. Ezell showed slides and discussed common and uncommon medical and surgical conditions seen in the practice of gynecology. Dr. Nathan S. Hale, president, presided.

### HAMILTON

"Differential Diagnosis of Abdominal Pain," was the topic of discussion at the February 16 meeting of the Academy of Medicine of Cincinnati. Moderator of the panel discussion was Dr. C. Rollins Hanlon, professor of surgery, St. Louis University School of Medicine. Also presenting the subject were Dr. Joseph Kirsner, professor of medicine, University of Chicago, and Dr. Harry Mellins, professor of radiology, Down State Medical Center, Brooklyn, N.Y.

## Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

### CLARK

The Clark County Medical Society has established a student loan fund at Wittenberg University in the name of the late Ray M. Turner, M. D., with a pledge of \$1,200 over a six-year period. Dr. Turner, who died in April of 1964, was a practitioner of long standing in Springfield, was past-president of the Clark County Medical Society and a former Councilor of the Second District for the Ohio State Medical Association.

### GREENE

Dr. Robert L. Taylor of Dayton addressed the Green County Medical Society Thursday morning (Feb. 11) at Greene Memorial Hospital.

A thoracic surgeon, Dr. Taylor discussed diagnostic problems of the chest, defining various abnormalities seen in chest X-rays and the proper interpretations and diagnosis.

Dr. R. David Warner, president, conducted the meeting which was attended by 19 members.—*Xenia Daily Gazette*.

## Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

### ALLEN

The regular meeting of the Lima and Allen County Academy of Medicine was held at the Shawnee Country Club with 78 members and guests present. Dr. Vernon A. Noble presided. Dr. William Collins introduced the speaker, Dr. Edward A. Gall, chair-

man and professor of the Department of Pathology at the University of Cincinnati Medical School. Dr. Gall gave an illustrated lecture on "Lymph Node Biopsy."

Dr. D. W. English, chairman of the Public Relations Committee, announced a series of radio presentations on Medical Problems over WIMA. These are to be given once a month from February through June covering (February) Medical Problems and care after 60, (March) Medical Management of Pregnancy, (April) Medical Problems of Pre-School Children, (May) Cardio-Vascular Disease, (June) Cancer — Progress in Research, Detection and Treatment. — T. D. Allison, M.D., Secretary-Treasurer.

## Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

### LUCAS

The February program of the Academy of Medicine of Toledo and Lucas County included the following features:

February 12, General Practice Section — "Practical General Considerations in Anesthesia for All Practitioners," Dr. Paul Ditmyer and Dr. Robert Taylor.

February 18-19, Postgraduate Lecture Series — Presented by the Medical Advancement Trust of Maumee Valley Hospital and the Northwestern Ohio Heart Association; Guest Lecturer, Dr. William J. Kolff, Department of Artificial Organs and Kidneys, Cleveland Clinic; theme of program, "Artificial Organs and Kidney Transplantations — 1965."

### WOOD

Dr. William T. Jerome, III, president of Bowling Green State University, spoke at the dinner meeting of members of the Wood County Medical Society and the Wood County Bar Association, and their wives, at the Midway Nite Club, Bowling Green on February 18.

## Fifth District

(COUNCILOR: P. JOHN ROBECHER, M. D., CLEVELAND)

### ASHTABULA

*The Star-Beacon*, Ashtabula newspaper, featured a program of the Ashtabula County Medical Society in a three-column illustrated article.

Guest speaker for the occasion was Dr. Robert E. Tschantz, Canton, OSMA President, who discussed "The Eldercare Act of 1965," contrasting features of the proposed bill before Congress with those of the administration-backed Medicare program.

Posed with Dr. Tschantz in the newspaper photograph were Dr. Harmon Tidd, president of the Society, and Dr. William Doran, secretary-treasurer.

### CUYAHOGA

The March calendar of the Academy of Medicine



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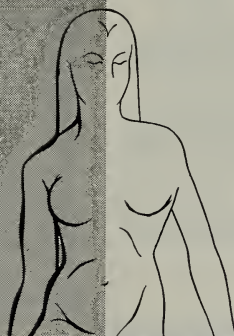
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of Cleveland and Cuyahoga County included the following features of medical interest:

March 10 — Heart Association Scientific Council meeting.

March 10 — Cleveland Rheumatism Society Journal Club meeting.

March 11 — Ninth Carl H. Lenhart Memorial Lecture; speaker Dr. Lester R. Dragstedt.

March 17 — Cleveland Neurological and Psychiatry Society meeting.

March 22 — Cleveland Radiological Society dinner meeting.

March 24 — Academy of Medicine dinner meeting; speaker, Dr. Harold D. Dalgleish, Saskatoon, Saskatchewan.

March 25 — Cleveland Dermatological Society meeting.

### Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

#### COLUMBIANA

Dr. Philip Ambuel, of Columbus, was guest speaker for the Columbiana County Medical Society dinner meeting held at the Wick Hotel in Lisbon on

February 16. His subject was "Congenital Heart Diseases of the Newborn."

Dr. Richard A. Dietrich, of LaRue, spoke at a meeting of the Mid-Century Mothers' Club in Mt. Victory, where he discussed the menopause.

Dr. Grace Hofsteter, Canton, spoke before a dinner meeting of the East Central Ohio Heart Association in Orrville, where she discussed heart disease.

Dr. Frank F. A. Rawling was named Toledo's Outstanding Salesman of the Year, by the Toledo Sales and Marketing Executives Club, for his work as "a prime mover in the successful efforts to have the University of Toledo campus selected as the site of a new state medical college."

Dr. John A. Prior, associate dean at Ohio State University College of Medicine, was one of five faculty members of the University selected for distinctive service.

Dr. Robert S. Martin addressed the Zanesville Kiwanis Club luncheon meeting, where he described programs of the American Medical Association.

Dr. Robert H. Schoene was elected president of the Columbus Bureau of Medical Economics. Other offi-

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cers are Dr. Robert P. Merrill, Jr., vice-president, and Dr. John P. Smith, secretary-treasurer.

Dr. Donald R. Wenner, Bucyrus, discussed methods of resuscitation before a meeting of the Crawford County District of the Ohio State Nurses' Association.

Dr. Jack Schreiber, Canfield, was speaker at the Ladies' Night meeting of the Jaycees of Salem. His topic was, "What Medicare Means to You."

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### LORAIN

Ninety-five physicians and their wives attended the March 9 regular meeting of Lorain County Medical Society at Oberlin Inn. The meeting was preceded by a Social Hour and dinner.

Dr. Richard Williamson, of Huron, gave an illustrated program on the fabulous mansions of Newport, R. I., which are being preserved by interested citizens of the area, and are open to the public.

During the business meeting which preceded the program, the membership stood in silent tribute to

their late colleague, Michael Varga-Sinka, M. D., for whom Dr. Delbert L. Fischer gave a moving Memorial Address.

Unanimously elected to Associate Membership in the Lorain County Medical Society were Jess S. Belza, M. D., of Wellington, and Howard A. Dillon, M. D., of Lorain. Robespierre T. Tumboken, M. D., a Fellow in Radiology at St. Joseph Hospital, was unanimously elected to intern membership in the Medical Society.

A special assessment to defray expenses of the local activity in presenting the merits of Elder-care as opposed to Medicare, was approved by the membership.

Dr. John Wherry reported on activity to date, which included an open Forum "Your Doctor Speaks — Eldercare versus Medicare" on Sunday, March 7; an extensive mailing of material to influential persons in the county; five taped interviews by physicians, which are being carried four times daily on the local radio station; Kaffeeklatsches arranged by the Woman's Auxiliary and a number of speeches by individual physicians.



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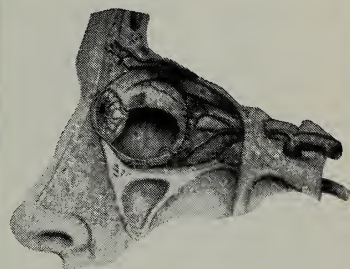
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# Woman's Auxiliary Highlights ...

By MRS. S. L. MELTZER, Publicity Committee  
Chairman, 2442 Dorman Dr., Portsmouth

IT WAS the year 1940 — it was the annual convention of the Ohio State Medical Association — it was the first time the soft cry of the newly born Woman's Auxiliary was heard. Yes, believe it or not, it happened 25 years ago! There are still a surprising number around who remember the birth pangs. . . .

The Auxiliary has come a long way since that year of 1940. And because we can point with justifiable pride to our accomplishments, this convention of 1965 becomes particularly meaningful, particularly important and particularly to be attended by what should be a 100 per cent dedicated membership. Any Silver Anniversary is a special occasion. This one most certainly is. Mrs. John D. Dickie of Toledo will preside as President.

Get your little black book (or red or green or brown or what have you) and mark down the dates in great big letters: May 12 and 13. Columbus is the place, and more specifically, Christopher Inn at 300 East Broad Street. The opening session is Wednesday morning, the 12th, with the Doctors' Day luncheon scheduled for that noon. Invite your husband for a truly delightful "break" in his day's heavily scheduled program.

On Thursday morning, the 13th, we will have the privilege of hearing Mrs. William H. Evans of Youngstown, our National President, and Dr. Henry A. Crawford, the newly elected President of the Ohio State Medical Association. Mrs. Evans will install the new officers, followed by Mrs. Herbert Van Epps of Dover, the incoming Auxiliary President, who

will deliver her inaugural address. The luncheon that day will smack of something extra-special: Mrs. Jerrie Mock who made that memorable around-the-world flight last year will be the featured speaker. Elsewhere in this issue is a more detailed program of the Auxiliary convention. Also read your Auxiliary News carefully for the "What and Why and When, the How and Where and Who." I'll dare to add one more note: Mrs. H. I. Humphrey, 389 South Drexel Avenue, Columbus, is convention chairman; Mrs. Joseph F. Tomashefski, 2071 Ellington Road, Columbus, is co-chairman.

## "Lend Us Your Ears"

It is not only interesting but informative to find out what other county auxiliaries are doing. Fairfield County's February meeting highlighted a luncheon and guest speaker at the home of Mrs. George Fred Jones of Lancaster. Patrolman R. D. Page, of the Ohio State Patrol, presented a film, "Freeway Driving," and then in the question and answer period that followed alerted his listeners to the dangers of driving on the new highways, and safety precautions to follow.

Mrs. Andrew Essman, auxiliary president, conducted the business session. The Paramedical Careers Committee, with Mrs. William S. Jasper as chairman, has been completing plans for an important project, and there was the further announcement that a loan fund is now available to first-year students in a career in one of the many health fields.

Mrs. Jones, hostess for the luncheon meeting, was

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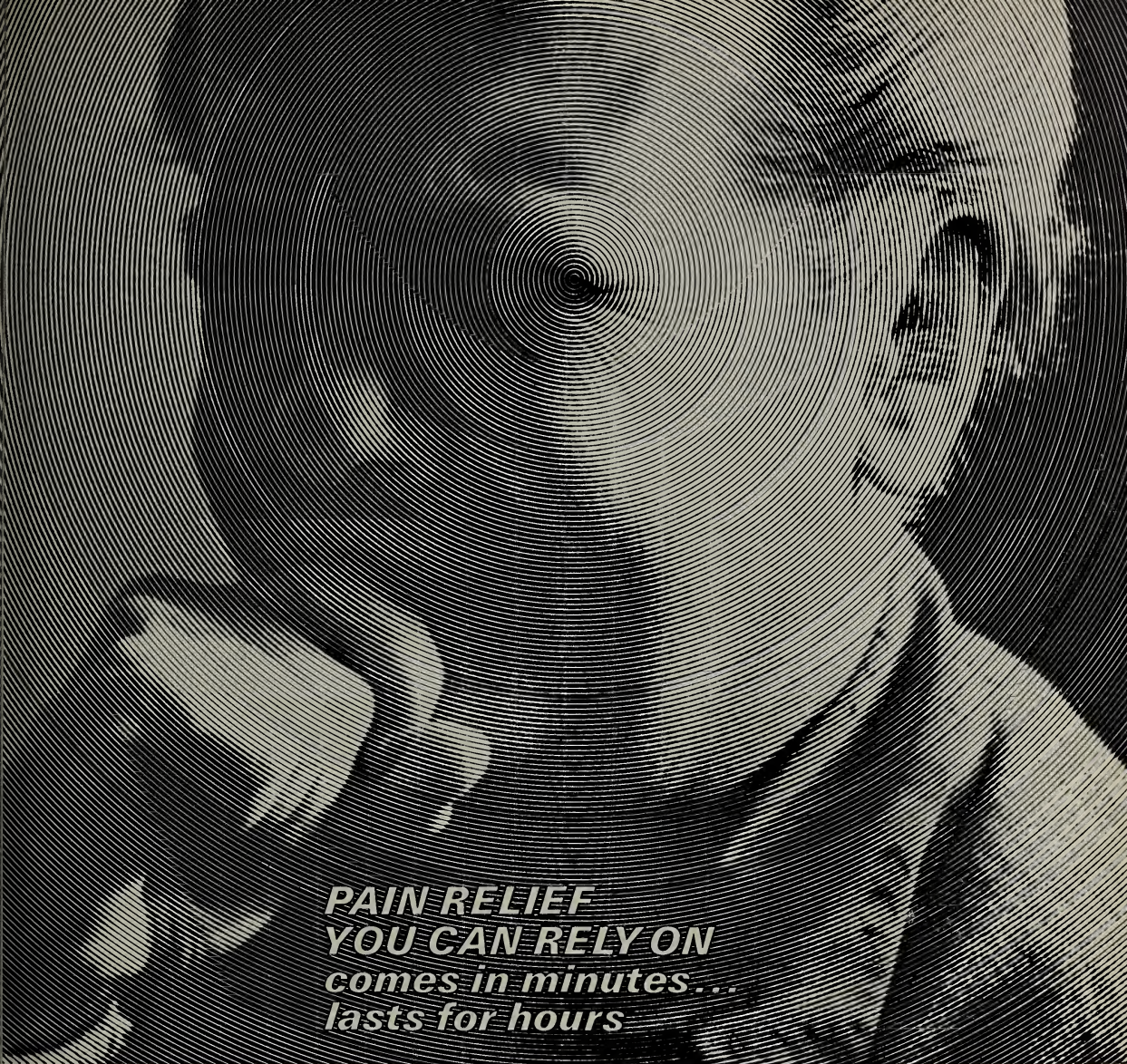
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#### Another Silver Anniversary

The Hamilton County Auxiliary is also heralding its twenty-fifth year and to celebrate the occasion a luncheon was held in February at the Skyline Room of the Terrace Hilton Hotel. A whimsical history in verse saluting past-presidents featured the birthday observance. Mrs. Harry L. Fry authored the presentation. Also taking part were Mrs. F. L. Mendez, Jr., program chairman, Mrs. Robert L. Coith and Mrs. Henry Clay Beekley. It is worth noting that Hamilton Auxiliary has contributed three state presidents: Mrs. Dale P. Osborn, Mrs. Paul Woodward and Mrs. Calvin F. Warner.

Another feature was the talk on "French Wine Service" by Henri Guglieimi, maitre d'hotel of the famous Gourmet Room. Mrs. William P. Jennings and Mrs. Mervin F. Stevens, hospitality chairmen, planned a social hour preceding the luncheon. A vineyard theme was suggested in the table decorations designed by Mrs. Warren K. Marvin. Mrs. Richard H. Tapke was in charge of reservations. Also serving on the anniversary committee were Mrs. Donald B. Miller, program vice-chairman, Mrs. Nelson R. Cragg, and Mrs. William DeVaux.

#### Lucas County's Study Group

A practical knowledge of family finances is the goal of a current study group in the Lucas County Auxiliary. There are five seminars: Banking Services, Necessary Insurance, Retirement Programs, Wills and Trusts, Stocks as Investments. The study group, organized by Mrs. J. Miller Hallauer, is in the capable hands of a New York Stock Exchange representative and a Toledo banker who lecture and lead each discussion group.

Lucas County members have also been busy in International Health. February was the month for a series of luncheons honoring the wives of foreign doctors as well as women physicians from foreign countries who are working in Toledo hospitals. The luncheons have been held in the homes of Auxiliary members and have purposely been kept small to make of them intimate, friendly get-togethers. Another endeavor along the line of International Health

has been Lucas County's active participation in the contribution of drug samples. (Good thing Toledo isn't too far from Detroit where such samples have to be brought). Mrs. Max T. Schnitker, the program's state chairman, is always "loaded down" (happily!) because she carries via station wagon not only her own county's contributions but that of the rest of the state! An Oscar to Mrs. Schnitker....

Six evening classes for the Expectant Parent are being sponsored from March 9 to April 13 as part of the Auxiliary's Family Life program. Dr. Bryne Marshall of Ann Arbor is the lecturer for this informative series.

#### Preservation of Natural Resources

Mr. Dale E. Whitesell, chief of the Wild Life Department in the Ohio Department of Natural Resources, addressed the March meeting of the Scioto County Auxiliary at the home of Mrs. Jack D. MacDonald, Portsmouth. The state executive spoke following a dessert luncheon.

Mr. Whitesell not only emphasized the importance of the preservation of wild life but discussed the vital health aspects concerning pollution of streams and rivers and the dangers of depleting our natural resources upon which the very life of our country depends. He also explained the plan to add outdoor recreational areas with cabins and lodges, beaches for swimming, lakes for fishing, nature trails and bridle paths in certain designated sections.

At the business meeting conducted by Mrs. Francis Kulсар, president, the members voted a \$200 donation to the current Ohio University Portsmouth Development campaign as a memorial to the late Mrs. T. C. Crawford. Assisting Mrs. MacDonald, the hostess, were Mrs. Louis R. Chaboudy, Mrs. Spencer W. Miller and Mrs. Armin Melior.

#### Bowling — for More Than Fun!

Stark County Auxiliary members are bowling for fun and what is even more important, for a handy \$1,000 for its Nurses' Scholarship Loan Fund. The group's Bowling League was organized last September, with a Canton Surgical Supply Company sponsoring the play at the Hall of Fame Bowling Lanes.

Mrs. Jack G. G. Hendershot is president of the league. Other officers include: Mrs. Richard Spitzer, vice-president; Mrs. Roy H. Clunk and Mrs. C.

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It is noteworthy that assistance from the scholarship fund dates back to 1937 (Stark County pre-dates the state in Auxiliary activity). Since that time, the group has helped 75 students and at present has 10 students enrolled in schools of nursing. Nine of these students are in Canton's Mercy Hospital School of Nursing and are second and third year students. The tenth girl is in her third year at the University of Cincinnati. Before the organization of the Bowling League, scholarship loans were supported by an annual benefit dance.

### A Professional Get-Together

Approximately 130 dentists, physicians, attorneys and their wives were fêted at a banquet meeting sponsored by the *Tuscarawas Auxiliary* in February at the Union Country Club in New Philadelphia. There was an address of welcome by Mrs. E. R. Hammersley, Auxiliary president, following which Dr. Raymond Crawley of Dover introduced the guest speaker, Attorney Sherlock Evans of Massillon. Mr. Evans captivated his audience with his well-directed humor (mixed with facts) about today's juveniles, the world situation, doctors and doctors' wives.

### Cleveland Area Supply Company Announces Medical Mart

The annual Medical Mart sponsored by The Schuermann-Jones Company of Cleveland will be held in the company's new warehouse and main office building at 3030 West 117th Street, Cleveland, Wednesday and Thursday, April 28 and 29, from 2 to 9 p.m.

Robert and Howard Schuermann, president and vice-president, respectively, have arranged a complete exhibition of equipment. Interns and residents are especially invited. The entire staff of the company, plus representatives from manufacturers of equipment will be on hand to answer questions.

## Midwestern States Symposium On Noise in Industry

The Institute of Industrial Health of the University of Cincinnati sponsored a highly successful "Symposium on Noise in Industry," in Cincinnati, on February 4 and 5, 1965. The two-day meeting was held at the Netherland Hilton Hotel in downtown Cincinnati, and 193 participants attended.

Those in attendance represented over 100 different companies located in the Midwestern states. Among the professions represented were Industrial Medicine, Safety Engineering, Acoustical Engineering, Personnel, Industrial Hygiene, Labor Relations, Nursing and Otolaryngology. Representatives of the military services, industrial management, labor unions, governmental agencies, and industrial insurance firms were present.

The program covered such topics as "The Ear, Hearing, and Noise," "Noise Control," "Hearing Testing in Industry," "Damage Risk Criteria," "Personal Protection," "Hearing Conservation in Large and Small Industrial Plants," "Insurance-Legal Aspects of Occupational Hearing Loss," and "Industrial Noise and Personnel Problems." Nationally known speakers covered each of these topics, and several "Round Table" sessions gave the audience the opportunity to question the speakers in detail on matters within their special fields.

The featured speaker at a dinner meeting was Dr. Aram Glorig, Director of Research for the Subcommittee on Noise of the American Academy of Ophthalmology and Otolaryngology, who spoke on "Medical Aspects of Occupational Hearing Loss."

The Symposium was sponsored by the Kettering Laboratory, The Committee on Occupational Health of the Ohio Medical Association, and S. K. Foster and Associates, Incorporated. Another, more detailed, Symposium on this subject is projected for next year.



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**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.  
**WYANDOT**—Franklin M. Smith, President, E. Saffie Ave., Box 58, Sycamore; Robert E. Goyne, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

### Fourth District

Councilor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

**DEFIANCE**—John W. Cullen, President, Box 218, Defiance; William S. Busted, Secretary, Box 218, Defiance. 1st Saturday, monthly.  
**FULTON**—Benjamin H. Reed, Jr., President, 101 Adrian St., Delta; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon. 2nd Tuesday, March, June, September and December.  
**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon. 1st Tuesday, monthly.  
**LUCAS**—R. Philip Whitehead, President, 424 W. Woodruff Ave., Toledo 43602; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday.  
**OTTAWA**—Robert Reeves, Port Clinton Road, Oak Harbor; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.  
**PUTNAM**—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Luginbuhl, Secretary, Pandora. 1st Tuesday monthly.  
**SANDUSKY**—J. L. Zimmerman, President, Memorial Hospital, Fremont; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.  
**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.  
**WOOD**—Louis P. Baldoni, President, 138 E. Front St., Perryburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

## Fifth District

Councilor: P. John Robeck, Cleveland 44106  
 10525 Carnegie Ave.

**ASHTABULA**—Harmen O. Tidd, President, 362 Rogers Place, Ashtabula; William F. Doran, Secretary, 241 Mill St., Conneaut. 2nd Tuesday, monthly.  
**CUYAHOGA**—Middleton H. Lambright, Jr., President, 10616 Euclid Avenue, Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland, 6.  
**GEAUGA**—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.  
**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

## Sixth District

Councilor: Edwin R. Westbrook, Warren  
 438 North Park Ave.

**COLUMBIANA**—Peter Cibula, President, 356 E. Lincoln Way, Lisbon; Ernest P. Schaefer, Secretary, 190 Penn Ave., Salem. 3rd Tuesday, monthly.  
**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.  
**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.  
**STARK**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 44702. 2nd Thursday, monthly.  
**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.  
**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

## Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry  
 30 S. 4th St.

**BELMONT**—Robert N. Lewis, President, 100 W. Main Street, St. Clairsville; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.  
**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.  
**COSHOCTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.  
**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.  
**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.  
**MONROE**—Ronald E. Christman, Jr., President, 104 N. Sycamore St., Woodsfield; Byron Gillespie, Secretary, S. Main St., Woodsfield.  
**TUSCARAWAS**—S. H. Winston, President, 658 Boulevard, Dover; G. W. Johnston, Secretary, 658 Boulevard, Dover. 2nd Thursday, monthly.

## Eighth District

Councilor: Robert C. Beardsley, Zanesville  
 2236 Maple Ave.

**ATHENS**—Robert E. Main, President, 400 East State Street, Athens; Lester A. Hamilton, Secretary, 400 East State Street, Athens. 2nd Tuesday at noon, monthly.  
**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hodsons, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.  
**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Senecaville; Dayle O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.  
**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.  
**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.  
**NOBLE**—F. M. Cox, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.  
**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.  
**WASHINGTON**—Donald Fleming, President, Vincent; Archbold M. Jones, Jr., Secretary, 326 Third St., Marietta.

## Ninth District

Councilor: George N. Spears, Ironton  
 2213 S. 9th St.

**GALLIA**—Leonard Harris, President, Holzer Clinic, Gallipolis; James A. Kemp, Secretary, Holzer-Clinic, Gallipolis. Quarterly meetings at called times.  
**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.  
**JACKSON**—A. R. Hambrick, President, Wellston; John C. MacLennan, Secretary, Oak Hill. Meeting date varies.  
**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.  
**MEIGS**—Selma J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once, monthly.  
**PIKE**—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.  
**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.  
**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

## Tenth District

Councilor: Richard L. Fulton, Columbus 43212  
 1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.  
**FAYETTE**—Thomas J. Hancock, President, 220 E. Market St., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 2nd Friday, monthly.  
**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.  
**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.  
**MADISON**—Francis E. Rosnaple, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.  
**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.  
**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.  
**ROSS**—Paul F. MacArthur, President, 60 Central Center, Chillicothe; Robert L. Counts, Secretary, 56 E. Second St., Chillicothe.  
**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

## Eleventh District

Councilor: L. C. Meredith, Jr., Elyria  
 205 Elyria Block

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Glen, California, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.  
**ERIE**—Fred Lavender, President, 1213 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P.O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.  
**HOLMES**—Owen F. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.  
**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.  
**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.  
**MEDINA**—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.  
**RICHLAND**—Stanley L. Brody, President, 327 Park Ave. W., Mansfield; Wendell M. Bell, Secretary, 425 Glessner Ave., Mansfield. 3rd Thursday, monthly.  
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# Areawide Health Facilities Planning ...

## Surge of Interest in This Field Points Up Responsibility Of Medical Profession To Assume Leading Role in Programs

By WILLIAM R. SCHULTZ, M. D.\*

**P**RESENT application and growth of interest in areawide health facility planning is reaching flood proportions, and every physician must take an interested and active role in such planning to assure proper medical orientation.

Any community planning to build a hospital has always based its decisions as to size, location, and scope of operations, knowingly or not, on some type of area planning by the leaders of that community.

Today, we are faced with more formal and sophisticated planning, with specialists in the field using charts, graphs, surveys, computers, and a whole new vocabulary to arrive at decisions and justify the position taken.

Why this seemingly sudden interest in areawide planning of health facilities? Several facts are worthy of consideration and the following are listed, not necessarily in the order of their importance:

1. The demand for short-term acute-care facilities has been satisfied in many areas. The U.S. Surgeon General's office and Hill-Burton officials state that 83 per cent of the general hospital beds needed now have been built, as contrasted with only 59 per cent in 1948. Therefore, there is more need for discriminate study and building today.

2. The rapid rise of operating costs of general short term hospitals. The per diem cost in 1963 was \$38.91, a rise of some 95 per cent in 10 years. During this same period, the consumer price index rose only 16 per cent. This cost rise is reflected in both hospital bills and increased health insurance premiums.

3. The establishment of a research grant program authorized by the Community Health Services and Facilities Act of 1961, which since then has become a section of the Hill-Burton Act. This program distributed some \$3,000,000 in the form of demonstration grants, beginning in June of 1961. Under the Harris Bill enacted in 1964, there will be some 22½ millions available over the next five years for "Studies and Demonstrations Relating to Coordinated Use of Hospital Facilities."

\*From an address at the 1965 Ohio State Medical Association Conference for County Medical Society Officers, Columbus, February 28, by Dr. Schultz, of Wooster, Ohio, Chairman, Committee on Hospital Relations, OSMHA.

### Acute Needs Being Met

Since most of the acute needs for beds have been satisfied, the interest and attention of planning today is turning to new concepts of total health area planning which evaluates all health facilities, patterns of medical care, changing technological advances, hospital costs and use, and total health expenses.

Today's areawide planning is a systematic attempt, first to measure the total health needs of an area and the factors influencing those needs, and next, to consider all available health care resources and determine the effectiveness with which they are meeting health care needs. From this knowledge, a master plan is developed that integrates, coordinates, and develops health care facilities in such a way that high standards of health are maintained and made available to all who need them, while still holding the cost of this care to the lowest possible levels.

Areawide planning involves itself with under-utilization as well as over-utilization. Its goal is to make facilities available where they are needed and to prevent their development where they are not needed. It requires the solid support of the hospitals, medical profession and all health care agencies whose chief motivating force should be to provide the highest quality of medical care possible within the limits of any given situation and area.

Prior to 1946, only two states had areawide planning agencies. Today, there are some fifty agencies in the United States covering areas in which some 40 per cent of the nation's physicians are practicing. Most of us now or soon will be in areas with some form of health facility planning and the broadening scope of these agencies will have a direct effect on the future of all medical practice.

### Medicine Must Participate

Therefore, we must all be aware of these changes and take an active part in shaping them to provide the best care possible for all the people of this country as well as serve the principle of voluntary regulation of *each* area's medical needs.

Governing boards of planning agencies are made up of representatives of business, labor, medicine, hospitals, and the general public. However, there has



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for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

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**References:** 1. Hanson, R. J., *et al.*: J. Urol. 79:1016 (July) 1958. 2. Middletown, J. E.: Brit. M. J. ii:497 (Aug. 31) 1957. 3. Today's Drugs, Brit. M. J. i:1475 (May 26) 1962. 4. Brumfitt, W., *et al.*: Lancet i:130 (Jan. 20) 1962. 5. Anderson, K. N., *et al.*: J.A.M.A. 187:87 (Feb. 22) 1964.

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been a reluctance on the part of some agencies to have any medical personnel on their policy-level boards and to regulate the medical profession to an advisory committee. These agencies all should be representative of the entire community, including concerned members of the medical profession.

The Columbus Hospital Federation has very carefully avoided the use of "advisory", and all committee appointments are board level. The medical profession is well represented and the officers of the Academy of Medicine of Columbus and Franklin County Medical Society speak officially for the medical profession.

The American Medical Association in 1962 adopted a resolution recognizing areawide hospital planning on a voluntary basis as an important method of providing health facilities and as a means to decrease the total cost of medical and hospital care.

This resolution encourages medical societies and individual physicians to exert leadership in the formation and operation of these planning bodies. In addition, it warns us to resist enabling legislation which would change this voluntary system to a compulsory system.

#### AMA Policy Reaffirmed

This policy was reaffirmed by the AMA in 1963 and again in 1964.

On November 28 and 29, 1964, the first National Conference on Areawide Health Facilities Planning was held in Miami Beach, Florida.

#### Significant Points Cited

In summary of this meeting the following points are of significant importance:

1. Areawide planning is here and will be an increasing force in the future planning and building of all health facilities in this country.
2. So far, voluntary agencies have been and can be successful.
3. Methods of control used to implement decisions of voluntary planning agencies have been
  - (a) To influence sources of charitable contribution for hospital construction (for example, while the Detroit areawide planning agency was being established, the philanthropic community called a two-year moratorium on all donations for hospital construction or expansion).
  - (b) To influence potential lenders of monies for hospital construction.
  - (c) Influence which can be exerted through Blue Cross in writing contracts which withhold or withdraw membership of a hospital not approved by the local planning agency (for example, a Michigan Supreme Court decision upheld Blue Cross in refusing to engage in prepayment contracts with a Mt. Clemens, Michigan, hospital constructed over objection of the Detroit planning agency).

(d) Influence exerted through distribution of Hill-Burton funds.

4. The voluntary planning agencies thus rely on logical persuasion and community pressures to enforce their decisions.

5. With the expansion of the program, there is an increasing interest on the part of state legislatures to shape the philosophy of this movement. Many believe that only through mandatory legislation can a planning agency have "teeth" to enforce its decisions. Here they set up governmental departments with final authority over all health facilities construction.

The recently enacted Metcalf-McCloskey Bill in New York State represents such legislation. Under this bill, the seven regional planning councils in New York State make recommendations regarding construction of hospital facilities, but the final authority rests with the State Hospital Review and Planning Council, a state agency. This Council also sets all standards and even approves the bylaws and rules under which the area planning agencies operate. It is this agency and only this agency that can authorize hospital construction.

6. Guidelines to establish the scope of areawide planning and the part total health care will and should play are not yet well defined. There must be more study to set acceptable standards.

The task is not impossible, (and I speak here of areawide planning) when it is worked out by reasonable people seeking reasonable goals who recognize the need and take action before the pressures of the need force them to be unreasonable. Further, any goal will be "reasonable" as long as its motivating force is concern over maintaining and improving the quality of health care being provided.

#### Warns of Consequences

Dr. Edward Crane, Jr., past-president of the Los Angeles County Medical Society, noted in his remarks at the Miami meeting, "There are those who would like to see the private practice of medicine become part of the hospital." He urged all County Medical groups to become active on community planning committees. He further stated that "future neglect of our responsibilities will result in hospitals, public health and planning organizations carrying the ball alone, and the goal line they cross might not be best for either our patients or the practice of medicine."

Government acts generally when there is a vacuum, and we must all play an increasingly dynamic role in the planning of areawide health facilities to prevent the development of such a vacuum and to preserve voluntary free enterprise which has brought medicine and our nation's health to its present high level of excellence.

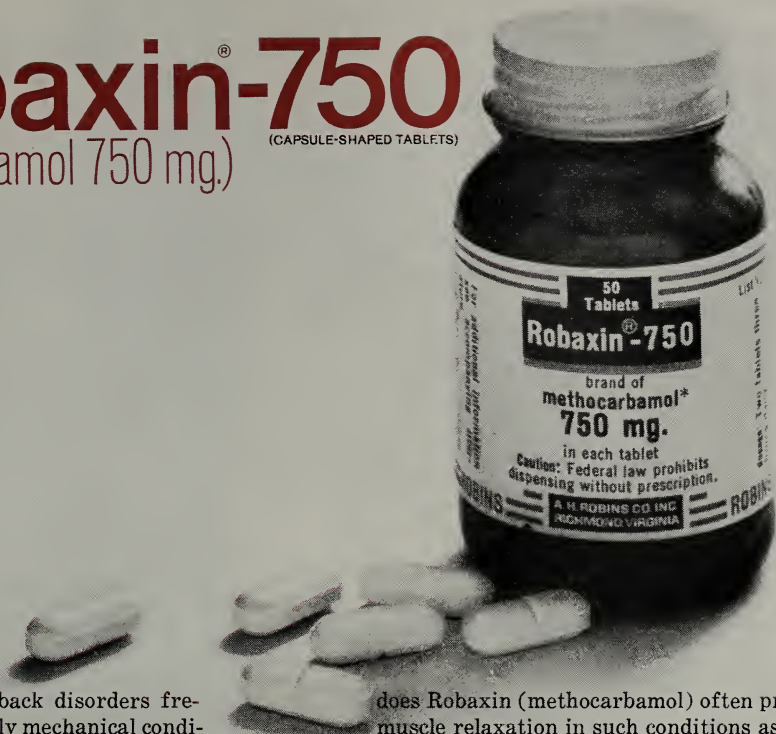
We must so order our house, orient our thinking, and make sacrifices of our time—to give of ourselves as leaders, rather than followers, to achieve that which we know is right and best for all concerned.



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**REFERENCES:** 1. Soto-Hall, R.: *Med. Sci.* 14:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See *Medical News: J.A.M.A.* 185:39 (July 13), 1963. 3. Gordon, E.J.: *Med. World News* 5:54, 1964. 4. Cozen, L.: *GP* 26:82, 1962. 5. Larson, C.B.: *Postgrad. Med.* 26:142, 1959. 6. Forsyth, H.F.: *J.A.M.A.* 167:163, 1958. 7. Weiss, M., and Weiss, S.: *J. Amer. Osteopath. Ass.* 62:142, 1962. 8. Rowe, M.L.: *J. Occup. Med.* 2:219, 1960.

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## Cleveland Health Museum Director Retires

Dr. Bruno Gebhard, director of the Cleveland Health Museum for its entire 25 year history, has announced his retirement effective July 1, 1965.

As of that date, Dr. Gebhard will become Director Emeritus of the Museum, and will serve as a consultant on special national and international projects with which the Museum has frequently been associated.

Dr. Gebhard came to this country in 1937 as a consultant to the medical and Public Health Exhibits at the New York World's Fair in 1939. He came to Cleveland in June of 1940 to become the first director of the first health museum in this hemisphere. From its infancy, the Museum has grown to become one of the world's foremost authorities in the field of public health education. Under Gebhard's direction, the Museum grew from an institution of seven employees, and an annual operating budget of \$25,000. Today there are 27 employees and an annual budget of \$250,000.

The most outstanding growth has been in the support by its local members, from 815 members in 1940 to 7,693 today, which makes the Cleveland Health Museum the largest local health education organization in the United States.

## Ohioans Among Participants in Medicolegal Symposium

Several Ohioans were among participants in the recent National Medicolegal Symposium jointly sponsored by the American Medical Association and the American Bar Association in Las Vegas, Nevada.

Wayne E. Stichter, Toledo attorney and legal counsel for the Ohio State Medical Association, discussed "The Legal Viewpoint" in a panel on the topic, "What Happens When a Physician Is Sued by a Patient?"

Robert S. Mauck, partner in Professional Practice Management, Columbus, spoke on the topic, "Business Problems of a Medical Practice."

Other participants included R. Crawford Morris and Michael R. Gallagher, Cleveland attorneys.

## Obstetrics and Gynecology

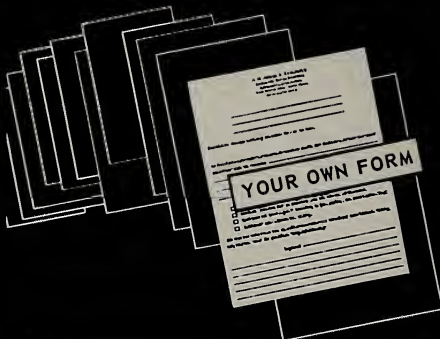
The next scheduled Part I written examination of the American Board of Obstetrics and Gynecology will be held in various examining centers in the United States, Canada, and military bases outside of the continental United States on Friday, July 2. Details in regard to requirements of the board may be obtained from Clyde L. Randall, M.D., Secretary and Treasurer, American Board of Obstetrics and Gynecology, 100 Meadow Rd., Buffalo, N. Y. 14216.

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## University Hospitals of Cleveland Centennial Symposium Program

A complete program has been printed for the Centennial Symposium of University Hospitals of Cleveland, to be held from Thursday, May 20 through Saturday morning, May 22.

General Sessions will be held on Thursday and on Friday morning, with Departmental Sessions on Friday afternoon and Saturday morning. The two general programs have been announced as follows:

### Thursday, May 20

#### The Functions of The University Hospital, — Past, Present and Future

"The Changing Responsibilities of the Hospital for the Graduate Education of Physicians," Thomas H. Hunter, M. D., University of Virginia School of Medicine

"The Changing Responsibilities of the Hospital for Undergraduate and Graduate Education in the Allied Health Sciences," Mary K. Mullane, Ph. D., R. N., University of Illinois College of Nursing

"The Role of the Hospital in Health Sciences Research," Ludwig W. Eichna, M. D., State University of New York, Downstate Medical Center College of Medicine

"The University Hospital as a Community Health Resource," John H. Knowles, M. D., Massachusetts General Hospital

"The Effect on the Community Hospital of the Changing Role of the University Hospital" — a panel discussion. Moderator: Joseph T. Wearn, M. D., Dean Emeritus, Western Reserve University School of Medicine

### Thursday Evening

"The Response of the University Hospital to its Changing Responsibilities," John S. Millis, Ph. D., President, Western Reserve University

### Friday Morning

#### Tomorrow's Critical Areas of Medical Research

"The Population Explosion and Its Impact on Health Sciences," Alan F. Guttmacher, M. D., Planned Parenthood Federation

"Advancing Frontiers in Immunology," Robert A. Good, M. D., University of Minnesota Medical School

"Expanding Concepts in Psychosomatic Medicine," Morton F. Reiser, M. D., Albert Einstein College of Medicine

"The Next 100 Years," Irvine H. Page, M. D., Cleveland Clinic

### Friday Afternoon and Saturday

Departmental Program will be held on Friday afternoon and some on Saturday morning. A complete program may be obtained by writing to Alan R. Moritz, M. D., Chairman, Symposium Planning Committee, 11000 Euclid Avenue, University Circle, Cleveland, Ohio 44106.

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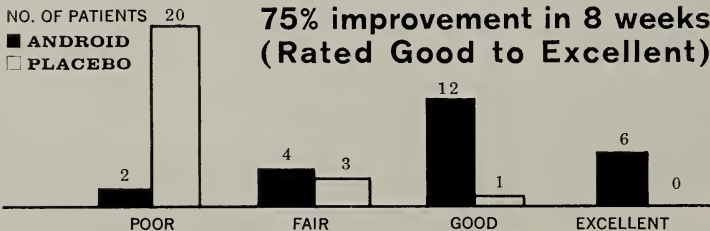
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- \* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.
2. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure Discussing Thyroid-Androgen Interrelationship.



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\* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

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Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220

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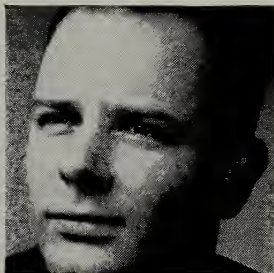
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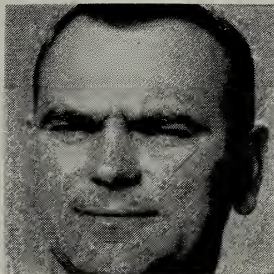
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# New Members...

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during March. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

## Ashtabula

John E. Venable, Jr.,  
Jefferson

## Athens

Bert A. Masters, Athens

## Clark

Theodore W. Werning,  
Dayton

## Cuyahoga

Joseph A. Bauer, Jr.,  
Cleveland  
Elena A. Geicys, Cleveland  
Phill I. Cohen, Cleveland  
Sharad D. Deodhar,  
Cleveland  
Miguel A. Dominguez,  
Cleveland  
Edward D. Frohlich, Cleveland  
James A. Grauel, Cleveland  
James S. Gutentag, Cleveland  
Edwin Hill, Cleveland  
Deane Hillsman, Cleveland  
Lansing C. Hoskins,  
Cleveland  
Jan K. Hull, Cleveland  
Robert W. Kellermeyer,  
Cleveland  
Donald J. Kurlander,  
Cleveland  
Spiros G. Kyrkos, Westlake  
James Magisano, Cleveland  
Richard Charles Miller,  
Cleveland  
Luceil B. North, Cleveland  
Eugene H. Patrick, Cleveland  
Antoni Rodriguez-Antunez,  
Cleveland  
Morton J. Sanet, Cleveland  
Bruce H. Stewart, Cleveland

## Fairfield

Richard E. Hartle, Lancaster  
Joseph F. Kirkpatrick,  
Lancaster

## Franklin

Gertrude E. Alexander,  
Columbus  
Henry G. Cramblett, Columbus  
Norman Davis, Columbus  
Frank J. Dawson, II,  
Columbus  
William E. Evans, III,  
Columbus  
Edmond J. Goold, Columbus  
Lloyd David Hall, Columbus  
Barry S. Hillman, Columbus  
George J. Learmonth,  
Columbus  
Michael M. Paparella,  
Columbus  
Roger W. Park, Worthington  
Charles D. Schloss, Columbus  
Marvin H. Spiegel, Columbus

## Gallia

Frederick W. Trapp,  
Gallipolis

## Greene

Paul Paine Webb,  
Yellow Springs

## Hamilton

Baltazar Anaya, Cincinnati  
Francis J. Froehlich,  
Cincinnati  
Alexander G. Garcia-Duarte,  
Cincinnati  
James T. Gourzis, Cincinnati  
Stephen J. Lewis, Cincinnati

## Lake

Severo R. Armada, Jr.,  
Mentor  
Thomas L. Schultz,  
Painesville

## Logan

Michael J. Kirk, Lakeview

## Lorain

Jess S. Belza, Wellington  
Robespierre Tumbokon,  
Lorain  
Richard C. Zbornik, Elyria

## Lucas

Charles M. Klein, Toledo  
Konrad Lasek, Toledo  
James E. Mann, Toledo  
Lawrence D. Pinkner, Toledo  
Ranieri Rocchi, Toledo  
Gerald W. Sutherland,  
Toledo  
Charles R. Tittle, Toledo  
Roland R. Wade, Jr., Toledo  
John R. Wesley, Toledo  
Vito Zupa, Toledo

## Mahoning

Karl T. Baumgaertel,  
Youngstown

## Marion

Raymundo Concepcion,  
Marion  
Hsing Kuo Wu, Marion  
James M. York, Marion

## Medina

Edward A. Kuehn,  
West Richfield

## Miami

Oresti T. Chiaffitelli, Piqua

## Montgomery

William J. Marshall, Dayton  
C. Roger Moritz, Dayton  
Donald W. Ogletree, Dayton

## Muskingum

Hudnall J. Lewis,  
Zanesville

## Pike

Joseph Benutto, Waverly

## Richland

Nagin Ranchod, Mansfield

## Shelby

Edward A. Link, Sidney

## Stark

B. W. Cruz, Canton

## Summit

George A. Tabakov, Akron

## Trumbull

Julio E. Cuesta, Warren

## Union

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\*Swartz, C., et al.: Circulation 28:1042, 1963.



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# The Two Hundredth Anniversary of American Medical Education

WARREN G. HARDING 2nd, M.D.\*

THE month of May 1965 is of particular interest to the Medical profession as the two hundredth anniversary of the establishment of medical education in Colonial America. A decade before the Revolutionary War the genius of the first American Professor of the Theory and Practice of Medicine outlined a plan for future medical schools which has only been consummated within the past 50 years. The city of Philadelphia, renowned in many fields, is this year celebrating the founding of the first Medical School in North America. The school, later to become the School of Medicine of the University of Pennsylvania was instituted in response to the inspiration and dialectic skill of John Morgan, M.D. The year long celebration will include the annual meetings of many of the most powerful national medical organizations in the United States.

## Colonial Medical Education

Prior to 1765 the medical needs of Colonial America were met by physicians trained in the schools of Europe or by apprentices trained by them during the activities of their practice. The requirements for this training were often related more to the needs of the doctor for service in caring for the office, horses, and the mixing of medicine than to an avid interest on the part of the practitioner in the problems of medical education. As a result, the standards of training varied from office to office. In many instances this haphazard educational system produced some outstanding physicians, but equally as often the preparation for practice was woefully inadequate. The opportunities of the advancing frontier communities absorbed more than its share of these incompetent men by virtue of the fact that they were available, and no means of comparing their work was available. Those students really desiring to become highly competent physicians felt obligated to

get their general education as offered in one of the colonial colleges and then to make the hazardous trip to a European University to study medicine.

John Morgan was born in 1735 in Philadelphia. The son of a successful local family, he was given the opportunity of attending the Philadelphia College, founded by Benjamin Franklin. He attended school and at the same time was apprenticed to the eminent Dr. Redman for a period of five years. Dr. Redman's interest in medicine, and particularly his interest in the training of the young men who applied to become his assistants, made his service most attractive and enabled him to select only the most promising candidates as his students.

After completion of his apprenticeship and graduation from the college in 1757 Dr. Morgan served for four years with the troops from Pennsylvania during the Seven Years' War. In this position he received an extensive experience in traumatic, nutritional, environmental, and infectious maladies, which convinced him of the necessity for a broad introduction to all phases of medicine. He also recognized 200 years ago the need for specialization, for no man could become competent in all of the disciplines peculiar to medicine. Fortunate in having ample financial backing he decided to go to Europe to study in the medical centers of London, Edinburgh, Paris, and Rome.

His European experience with such luminaries as Hunter and Munro, to mention only two, was highly successful, and he returned with his M.D. degree from Edinburgh and with memberships in medical associations in each of these areas where he pursued his studies. Most important for our purpose however was the conviction he developed that the opportunity for complete and adequate education in medicine must be available in America. Experienced in both Europe and America and fiercely proud of the potentials of the new world, he recognized that the problem was not one of transporting intact a Eu-

\*Dr. Harding, Columbus, is Director of Medical Education, Grant Hospital.

Submitted February 2, 1965.



ropean concept to America, where social and economic activities differed, but rather the adaption of the assets of European education to the needs of colonial life. While in Paris shortly before his return to Philadelphia, he wrote out his plan for American Medical Education, which, with a visionary's en-

vined them of the plausibility and desirability of the college assuming the leadership in establishing a medical college in America. So cogent and persuasive were his arguments that they responded to his presentation by electing him Professor of Medicine, in the modern sense, and arranged for him to be the

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Delivered at a Public ANNIVERSARY COMMENCE-  
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May 30 and 31, 1765.

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PREFACE

Containing, amongst other things,  
THE AUTHOR'S

APOLOGY

For attempting to introduce the regular mode of  
practising PHYSIC in PHILADELPHIA.

BY JOHN MORGAN M.D.

Fellow of the Royal Society at LONDON; Corre-  
spondent of the Royal Academy of Surgery at  
PARIS; Member of the Arcadian *Belles Lettres* So-  
ciety at ROME; Licentiate of the Royal Colleges of  
Physicians in LONDON and in EDINBURGH; and  
Profeffor of the Theory and Practice of Medicine  
in the College of PHILADELPHIA.

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FIG. 1. Title Page of Morgan's Published Discourse. (Taken from the Hopkins Reprint.)

thusiasm, he was confident could be established in Philadelphia.

#### Morgan's Proposal

Returning to Philadelphia in 1765, he interviewed the Board of Trustees of his alma mater and con-

principal speaker at the literary program of the college to be held on May 30, 1765. Morgan grasped this opportunity to present his educational plan under the title of "A Discourse upon the Institution of Medical Schools in America." This outline with

other comments was subsequently published by William Bradford. Fortunately *The Johns Hopkins Press* saw fit to reprint this classic in 1937<sup>1</sup> under the same title so that it is available and should be required study for any serious student of medical education.

### Broad Humanistic Base And Basic Science

John Morgan envisioned a system of medical training which embodied practically all the sound goals currently espoused in medical education. After defining medicine in its broad aspect as a "thorough knowledge of the human economy," he points out the necessity for an extensive acquaintance with the humanities as a basic study for the physician. To use his words: "young men ought to come well prepared for the study of medicine, by having their minds enriched with all the aid they can receive from the languages and the liberal arts."

At a period when most doctors were trained by apprenticeship in the care of disease, Morgan proposed a formal study of the preclinical sciences of Anatomy, Materia Medica and Botany, Chemistry, Pharmacy, Physiology, and Pathology. The synthesis of these sciences into the Institutes of Physic is emphasized: "Let no man lay claim to the dignified title of Physician who is not thoroughly conversant in the medical institution."

Morgan's interest in curriculum planning and methods is expressed as follows:

"For want of method, all his knowledge would be superficial: though he might take as much pains as would suffice to make him eminently skillful, had he from the beginning pursued a well concerted plan."

### Clinical Teaching and Continuing Education

Anticipating Osler's teaching of clinical medicine by over one hundred years, Morgan stated: "Observation and physical experiments should blend their light to dissipate obscurity from medicine." The

experience in a hospital oriented clerkship is recommended:

"Pupils here meet with such a number of cases, both chronic and acute, treated so judiciously, and so agreeable to the rules of Art, as cannot fail very much to facilitate the knowledge of their profession."

After carefully pointing out the need for the separation of medicine, surgery, and pharmacy into areas of specialization, he stressed the desirability of establishing a medical library in Philadelphia as a means of aiding the continuing education of the practicing profession in addition to its aid to the student. He demonstrated concern for the need of the practicing doctor to continue his role as a student, a principle to which so much attention is now being given by all those interested in the quality of medical service for the public. Expressing his contempt for those whose sole interest is in practice as contrast to a progressive interest in the theory which explains the basis for it, he comments:

"Let us rather commend those who would be afraid of making no further advance in the healing arts, if they were compelled to abandon study and to give themselves up wholly to practice; and who examine themselves every year, to know what progress they have made in the knowledge of diseases."

Thus 200 years ago, Morgan gave modern answers to the problems of premedical training, study of the basic sciences, broad clinical experience in a hospital environment, curriculum planning to give proper integration of concepts, the availability of the literature by means of a library, and lastly the necessity for continuing education. Morgan's discourse resembles an agenda for a present-day national conference on medical education.

The physicians of Ohio congratulate the Medical School of the University of Pennsylvania on their two centuries of progress and leadership in this important field. With humility we pay respect to the genius of one of our early confreres.

### Reference

1. Morgan, John: *A Discourse Upon the Institution of Medical Schools in America*. (Reprinted from the first edition), Baltimore: The John Hopkins Press, 1937.

---

**THE ART OF THE PRACTICE OF MEDICINE.** — He who practices the art of medicine at its best is likely to be more or less of a scholar. He has read extensively and probably has written and published on medical topics. With this experience he becomes keenly sensitive to poor phraseology, abbreviations and medical presentations at the bedside or in the convention hall that lack dignity. This custom of poor expression disappears abruptly if you and I, as teachers, instruct by example and never fail, in a kindly way, to draw attention to manners of speech not becoming to our profession. — Garfield G. Duncan, M. D., Philadelphia: *Military Medicine*, 126:355-358, May 1961.





# Scientific Section

VOL. 61

MAY, 1965

No. 5

## Abstracts from Regional Meeting of American College of Physicians

**EDITOR'S NOTE:** On January 22 and 23, 1965, the Regional Meeting of the American College of Physicians for Ohio, West Virginia, and Western Pennsylvania was held in Cincinnati. Dr. Ben I. Friedman of Cincinnati was Chairman of the Program Committee under the direction of Drs. Richard W. Vilter, Robert U. Drinkard, Jr., and William M. Cooper, Governors of the College for Ohio, West Virginia, and Western Pennsylvania, respectively. Through the courtesy of Dr. Friedman, we are pleased to publish abstracts of papers read at that meeting. They appear in the order of presentation.

This represents a new venture for *The Journal*, and we hope Program Chairmen of other regional organizations will follow Dr. Friedman's lead. In this way, we will be able to keep Ohio physicians better informed of clinical and research activities in our area.

\* \* \*

### Studies in Epidemiology and Treatment of Penicillin-Resistant Staphylococcal Infections in a Large Mental Hospital

Rae L. Hartman, M.D., Alfred Lustberg, M.D., Judith A. Carleton, B.A., Allen Straus, M.D., Nancy C. Scott, B.S., Gary Novak, B.A., and Morton Hamburger, M.D., F. A. C. P.

*From the Infectious Disease Division, Department of Medicine, University of Cincinnati College of Medicine and the Medical Services of the Longview State Hospital*

Soft tissue lesions caused by PNC-resistant staphylococci in a large Mental Hospital have been studied over a 3-year period, with respect to phage typing, antibiotic sensitivity pattern, and effect of antimicrobial chemotherapy on the rate of disappearance of the staphylococci from the lesions. Because of the size of the patient population, no attempt has been made to observe every patient with soft tissue lesions. Nasal carrier surveys of certain portions of the populations have helped understand the distribution of the various phage types of staphylococci.

Clinical observations and multiple semi-quantitative

cultures have demonstrated that lesions heal faster and staphylococci disappear more rapidly in patients treated with penicillinase-resistant penicillins than in those treated conservatively without chemotherapy.

Analysis of phage typing indicates that certain strains of pathogenic staphylococci, notably the 52/52A/80/81 complex, have persisted in patients and nasal carriers during the entire period of study. The spread of this strain among the patients in one room of a large dormitory was of particular interest.

\* \* \*

### Experiences with Cephalothin Treatment of Infections

Robert L. Perkins, M.D., and Samuel Saslaw, M.D., F. A. C. P.

*Department of Medicine, Ohio State University  
Columbus, Ohio*

Cephalothin (Keflin-R), a new antibiotic released for use in September, 1964, was used in a clinical study to treat infections in 51 adult patients. Thirty-four patients had serious underlying disease; twenty

had malignant or otherwise incurable disorders co-existent with their infection. Etiologic organisms included *Staphylococcus aureus*, *Kelbsiella pneumoniae*, *Escherichia coli*, *Hemophilus influenzae*, *Pseudomonas aeruginosa*, *Diplococcus pneumoniae*, and a number of mixed Gram-positive and Gram-negative combinations. Types of infection consisted of pneumonia, abscesses, pyelonephritis, osteomyelitis, endocarditis, and septicemia.

Therapeutic success was obtained in 86 per cent of Gram-positive and 55 per cent of the Gram-negative infections due to a single organism, 28 per cent of mixed staphylococcal and Gram-negative infections, and 42 per cent of those with negative cultures. The low cure rates are thought to reflect in part the seriousness of underlying disorders.

Eleven patients with known penicillin allergy and serious systemic infections were of particular interest. Ten responded dramatically to treatment without evidence of allergic reaction. One developed an erythematous rash attributed to cephalothin allergy. Two of 3 patients with acute renal failure and systemic infections recovered after cephalothin therapy.

Dosages ranged from 0.5 - 2.0 grams i. m. or i. v. q 4-6 hours. Infrequent toxic reactions were observed including drug fever, rash, phlebitis, and pain on i. m. injection in 2, 3, 3 and 4 instances, respectively.

Cephalothin appears to be effective in treatment of selected Gram-negative infections and of particular value in penicillin-allergic patients with systemic Gram-positive infections.

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### Percutaneous Suprapubic Aspiration Of Bladder

Leonard M. Goldberg, M. D., and  
Kenneth L. Vosti, M. D.

*Department of Medicine, University of Cincinnati Medical School,  
Cincinnati, Ohio, and Stanford University School of Medicine,  
Palo Alto, California*

The quantitative culture of voided urine is adequate for the identification of urinary tract infection in most clinical situations. However, there are occasions which require the collection of a specimen for culture which may be interpreted with greater accuracy. The culture of urine collected by percutaneous suprapubic aspiration of the bladder affords the most specific and sensitive method for the identification of bladder bacteriuria. The presence of bacteria in the bladder urine indicates infection regardless of numbers.

More than 300 aspirations of urine from the bladder were performed safely. Microscopic hematuria occurred in 40 per cent of post-aspiration voided specimens. Gross hematuria occurred in 3.5 per cent. Complications of unusual pain or anxiety occurred in fewer than 1 per cent. Neither infection nor extravasation of urine from the bladder following aspira-

tion were observed. All complications resolved without therapy.

Indications for aspiration of urine from the bladder include those situations when the bacterial count is expected to be low. Suppression of the bacterial count below 100,000/ml may be expected when antimicrobial drugs are in the urine, a high urine flow rate is present, or infection occurs with a fastidious microorganism.

Percutaneous aspiration of urine from the bladder is a safe, easily applied method for collection of urine for culture. It avoids the hazards of catheterization and provides the most sensitive and specific method for the detection of infected urine within the bladder.

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### Celiac Artery Obstruction

Floyd M. Beman, M. D., Samuel Marable, M. D.,  
William Molnar, M. D., and John D. Dunbar, M. D.

*From the Departments of Medicine (Gastroenterology), Surgery,  
and Radiology, The Ohio State University College of Medicine,  
Columbus, Ohio*

With the advent of transfemoral arteriography it has become possible to study more completely some of the relatively obscure cases of abdominal pain which one encounters. In the process of evaluating a large number of patients it has come to our attention that we have been seeing patients in whom a definite vascular bruit is heard over the upper part of the abdomen. Approximately twenty of these people have been studied exhaustively and it has been possible to localize the site of the bruit as due to a bandlike obstruction of the celiac artery at its point of origin from the abdominal aorta. Twelve of these patients have been operated and the lesion corrected.

This investigation was supported in part by the Public Health Service Research Grant No. FR-34 from the Clinical Research Center of the Ohio State University Hospitals.

\* \* \*

### Aortography as an Aid to the Localization Of Pheochromocytoma

David Z. Morgan, M. D.

*Department of Medicine, West Virginia University School of  
Medicine, and Medical Center, Morgantown, West Virginia*

Three cases are presented in which pheochromocytomas were precisely localized by retrograde aortography. One patient, a normotensive 23 year old pharmacy student was found, during routine screening of his class for experimental purposes, to have persistently elevated 24 hour urinary catecholamine levels ranging from 114-337 micrograms. Aortography established the presence of a right suprarenal tumor. A second case was unique in that aortography permitted the preoperative diagnosis of a pheochromocytoma of the organ of Zuckerkandl. This severely hypertensive woman, aged 28, had been thought to have renal artery stenosis because of the presence of a loud abdominal bruit. A retrograde



aortogram revealed tumor stain above the aortic bifurcation. The possible danger of aortography in pheochromocytoma has been documented (Saltz, N. J., et al. *Ann. Surg.*, 144:118-123, 1956). However, no complications were encountered with the single high pressure injection of 25 ml. of 90 per cent Hypaque® in these three patients. It is concluded that this procedure is relatively safe and may allow the exact localization of an abdominal pheochromocytoma. It should be considered, particularly when simpler roentgen techniques have been unsuccessful.

\* \* \*

### Renal Transplantation: A New Challenge In Therapeutics

Julio E. Figueroa, M. D., and  
Willem J. Kolff, M. D.

*From the Department of Artificial Organs, The Cleveland Clinic Foundation, Cleveland, Ohio*

With the advent of chemotherapeutic agents for the suppression of the immune rejection in homo-grafted tissues, the overall results of renal transplantation have steadily improved.

Since January, 1963, at the Cleveland Clinic, 41 renal homografts have been performed in 36 patients. Five patients each received a second kidney after failure of the first transplantation. Twenty-four patients are living and 23 have functioning kidneys. One patient is maintained on hemodialysis, awaiting a second transplant.

Twenty-two of the renal homografts in 20 patients were performed since January, 1964. Seventeen patients are living, with functioning kidneys from 1 to 10 months. Three patients died: two with overwhelming septicemia and one with an atypical pneumonia producing pulmonary insufficiency. Homografts were obtained from 17 cadaver donors and from 5 living donors.

The early results of renal transplantation are encouraging. Patients receiving successful renal transplants no longer suffer anemia, progressive neuropathy, uremia, electrolyte imbalance, or hypertension. Complete physical and mental rehabilitation has taken place, and some of the patients have resumed their jobs and lead normal lives. The long-term results of renal transplantation are still not known, but they improve along with advances in knowledge of the immunologic barrier and as experience is gained in balancing the immunosuppression against the depression of body defenses with chemotherapeutic agents.

The problems of immunorejection, infection, and donor availability are discussed in detail. A new approach to the procurement and preservation of cadaver kidneys is presented. We believe that in the near future, renal homotransplantation will be widely used in the treatment of chronic renal failure.

Supported by a grant from The John A. Hartford Foundation, Inc., to The Cleveland Clinic Foundation, for dialysis in the treatment of patients with chronic renal failure.

### Interstitial Nephritis, Papillary Necrosis And Excessive Phenacetin Ingestion

John R. Evans, M. D., William T. Carter, M. D.  
and James F. Schieve, M. D.

*Department of Medicine, The Ohio State University, Columbus, Ohio*

Renal damage secondary to excessive phenacetin ingestion was described by Spuhler and Zollinger in 1953. The nephrotoxic effects of phenacetin have been recognized clinically or diagnosed as interstitial nephritis or papillary necrosis. Since there is difficulty in the detection of the renal lesion by common clinical methods and doubt expressed as to the very existence of the disorder, we elected to review all of our cases of interstitial nephritis and papillary necrosis for a five year period for history of phenacetin ingestion.

Nineteen (19) cases of either interstitial nephritis (9) or papillary necrosis (10) were diagnosed histologically at Ohio State University Hospital during the five year period 1959-1963. The clinical records of these cases were reviewed for evidence of phenacetin ingestion. Twelve (12) patients (63 per cent) showed prolonged and excessive use of phenacetin, ingestion ranged from as low as 16 tablets per day for eight years to 20 tablets per day for 14 years. Five (5) patients had concomitant carcinoma diagnosed and five patients developed peptic ulcer disease (four of whom were treated surgically) while taking phenacetin.

All 12 of these patients complained of weakness, arthralgia, headache and epigastric distress. Associated laboratory findings were proteinuria, abnormal urinary sediment, elevated serum creatinine and anemia.

The association of interstitial nephritis or papillary necrosis with chronic prolonged ingestion of phenacetin is supported by this study.

\* \* \*

### Experiences with Inorganic Mercury Poisoning: Comparison of Results Of Treatment Before and After Availability of BAL

James Garfield, M. D., and  
E. Gordon Margolin, M. D.

*From the Jewish Hospital, and Cincinnati General Hospital, Cincinnati, Ohio*

Since the introduction of British Anti-Lewisite (BAL) into clinical medicine in 1946 by Leutscher and Longcope for the treatment of poisoning with heavy metals, this agent has been considered essential in treatment of mercury poisoning. Certain clinical observations in these patients led the authors to question the efficacy of this drug.

The charts of 109 patients with 111 episodes of Hg poisoning from 1940 to 1964 at Cincinnati General Hospital were reviewed. BAL became available in 1946; 55 of the cases preceded availability

of BAL and 56 followed BAL. The two groups of patients are comparable. Most of the patients ingested bichloride of mercury orally. Antibiotics and modern methods of management of anuria also became available about the same time as BAL and are important in evaluation of comparative results.

Only eight patients of the preBAL era were anuric, of whom six died; 14 of the BAL-treated group developed anuria and six of these failed to survive. The overall mortality rate was 11 per cent and 10 per cent in the two groups respectively. Anuria is rare when the dose of Hg is less than 2 grams whether or not BAL is given. No patients who ingested more than 4.0 Gm. of Hg Cl<sub>2</sub> survived despite the use of BAL.

It is suggested from the data that BAL plays only a minor role at most in the management of clinical mercury intoxication.

\* \* \*

### Necrotizing Angiitis: A Clinical Review Of Twenty-Seven Autopsied Cases

J. D. O'Duffy, M. D.

*From the Division of Medicine, Department of Rheumatic Disease,  
The Cleveland Clinic Foundation, Cleveland, Ohio*

All cases of necrotizing angiitis autopsied at the Cleveland Clinic from 1942 until 1962 are included. There were 27 cases in all, 20 men and 7 women. The incidence of major system involvement is discussed and comparison with several other major series previously reported is made.

An attempt to distinguish periarteritis nodosa of Kussmaul and Meier, from hypersensitivity angiitis of Zeek on the basis of clinical findings did not seem feasible. Pathologically the series consisted of 11 cases of hypersensitivity angiitis; 12 of periarteritis nodosa; and 4 of Wegener's granulomatosis. The latter cases contained distinctive features which rendered antemortem diagnosis possible.

Involvement of kidney, lung, heart, skin, central nervous system, gastrointestinal tract, muscles, joints, as well as, blood and eye were examined. The exact types of ocular and dermatological lesion were summarized. Electrophoretic protein analyses of seven cases revealed a consistent elevation of the Alpha 2 and Gamma globulins.

An interesting feature was the history in seven of the patients (26 per cent) of a significant traumatic event in the period immediately preceding the onset of the disease. This traumatic event in three cases consisted of a surgical procedure, and in four it was an accident. It is found that the incidence of significant recent trauma in this group of patients was higher than that of the history of clearcut drug allergy or recent systemic infection. Whereas, the roles of Drug Administration and Infection have received much emphasis in triggering the onset of arteritis, trauma has not previously been incriminated. The possible implications of the role of trauma in

necrotizing angiitis are discussed. A tentative theory of trauma-induced protein alteration in the vessel wall is entertained.

\* \* \*

### Intracardiac Phonocardiography In the Differential Diagnosis Of Continuous Murmurs

Thomas A. Huffman, M. D., Richard S. Goodwin,  
M. S., Joseph M. Ryan, M.D., F. A. C. P., and  
Charles F. Wooley, M. D.

*From Heart Station, University Hospital, Columbus, Ohio, and the  
Department of Medicine, The Ohio State University College  
of Medicine, Columbus, Ohio*

Continuous murmurs have been investigated in 12 patients ranging in age from 16 to 38 years, using intracardiac and external phonocardiography, conventional catheterization, and angiographic studies. Surgical confirmation was obtained in 11.

Murmurs produced by fistulous communications are intense, usually confined to a small area near the fistulous opening, and disappear rapidly as the intracardiac micromanometer is withdrawn.

A continuous murmur localized to the bifurcation area of the main pulmonary artery was found in six cases of patent ductus arteriosus, with obliteration of the external murmur by passing the catheter through the ductus in two.

In three patients with coronary arteriovenous fistulae, a loud, continuous murmur was localized to the high right atrium in two, and to the right ventricle in the third.

In one patient with a pulmonary A-V fistula, no murmur was found in the right heart proximal to the lesion.

The murmur produced by a ruptured sinus of Valsalva aneurysm was localized to the right ventricular outflow tract in one patient and in the low right atrium in another.

By contrast, two patients with to and fro murmurs due to ventricular septal defects and associated aortic insufficiency displayed only a systolic murmur in the right ventricle.

\* \* \*

### The Normal Cardiac Output as Measured By Precordial Scanning

S. L. Weinberg, M. D., G. R. Grove, Ph. D.,  
C. Benson, B. S., and E. L. Stanley, M. D.

*From The Research Department, Miami Valley Hospital,  
Dayton, Ohio*

Cardiac output is one of the most fundamental measurements of cardiac performance. This measurement, however, has never achieved extensive clinical application. Several reasons exist for this limitation in the use of cardiac output. The direct Fick technique requires cardiac catheterization. The dye dilution techniques require arterial sampling and are repeated with difficulty.

During the past ten years wide acceptance has been



given to the technique of estimating cardiac output by precordial scanning without arterial sampling. One such method has been developed by The Research Department of The Miami Valley Hospital and has been shown to compare with results obtained by the direct Fick technique although values are slightly higher. The method has been shown to be reproducible.

The technique described uses 8 microcuries of radioiodinated serum albumin injected intravenously for each determination. Each cardiac output measurement is an average of four sequential tests requiring a total of 32 microcuries for each series of determinations.

The present report presents the cardiac output values in 157 normal individuals. Numbers of males and females are approximately equal. Values for age decades in either sex are calculated from the third to the seventh decades inclusive.

The results are expressed in terms of blood volumes per minute. The thesis is made that this approach eliminates an unavoidable source of error by whatever means blood volume is calculated or estimated. Expressing the results in blood volumes per minute shows a consistent trend that the female output in terms of blood volumes per minute is higher than the male. When multiplied by blood volumes the usually accepted higher male cardiac output is observed. Mean values for each decade group with calculations of standard deviation are presented in such a way so as to serve as guide lines for this technique in routine clinical use where knowledge of changes in response to medication or varying physiological and disease states may be of value in the clinical care of the patient.

\* \* \*

### Combination of Selective Angiocardiology and Indicator Dilution Curves in Physiological Assessment of Unusual Intracardiac Shunts

Robert J. Marshall, M. D., M. R. C. P.

*From the Department of Medicine, West Virginia University School of Medicine and Medical Center, Morgantown, West Virginia*

The combination of selective angiocardiology and of indicator dilution curves with central injection and sampling sites provides more detailed information about intracardiac shunts than does either technique alone. In this paper the role of the combined techniques in the physiological assessment of some unusual varieties of shunts will be discussed. The shunts include the following: 1. Communications between the aorta and right ventricle. (a) Coronary artery-right ventricle fistula. (b) Aortic regurgitation associated with high ventricular septal defect. 2. Acquired patency of the foramen ovale. (a) With venoarterial shunt, secondary to severe pulmonary arterial hypertension. (b) With arteriovenous shunt, secondary to severe disease of the mitral valve.

### Clinical Experience with Elective "Cardioversion"

Robert S. Kozub, M. D., Thomas A. Huffman, M. D., Joseph M. Ryan, M. D., F. A. C. P., and Charles F. Wooley, M. D.

*From Heart Station, University Hospital, Columbus, Ohio, and the Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio*

Sixty-one patients, ages 22 through 81, were electively "cardioverted" (synchronized external direct current countershock) during a 20-month period beginning in 1963. Reversion to regular sinus rhythm was effected in 86 per cent of the procedures.

Forty-four patients had atrial fibrillation; 75 per cent of these patients were successfully cardioverted. The average duration of fibrillation in these cases was 18 months versus 35 months in the failures. Heart size had no apparent influence on the immediate results. Long term follow-up is in progress.

There were 17 patients with other arrhythmias, all of which were successfully cardioverted. These included 10 patients with atrial flutter, five patients with ventricular tachycardia, and two patients with paroxysmal atrial tachycardia.

No patient was prophylactically anticoagulated for the purpose of cardioversion. Fourteen patients were, however, receiving anticoagulants for other reasons. Ten patients were cardioverted after an unsuccessful attempt with quinidine, with seven successes. Digitalis intoxication was not a contraindication to this procedure in selected cases.

There were no complications. We concur with previous observations that cardioversion is a safe, effective, and frequently a preferred form of therapy for many arrhythmias.

\* \* \*

### Complete Heart Block: The Role of Interim Endocardial Pacemaking

A. C. Edmundowicz, M. D.

*From the Department of Medicine, West Virginia School of Medicine and Medical Center, Morgantown, West Virginia*

The transvenous insertion of an interim endocardial pacemaker catheter (Parsonnet et al. *Am. J. Cardiology* 10:261, 1962) prior to surgical implantation has many advantages. A bipolar electrode catheter is positioned in the Cardiac Catheterization Laboratory where measurements of cardiac output, stroke volume and arterial and venous pressures at variable heart rates are made to aid in cardiovascular evaluation. Stabilization of the ventricular rate prevents Stokes-Adams attacks and replaces emergency thoracotomy in these often elderly patients with a semi-elective procedure. The risks of anesthetic induction are reduced and improvement in cardiopulmonary and renal function and eradication of infections improve the surgical prognosis.

Prolonged endocardial pacemaking with conventional bipolar electrode catheters has certain disad-

vantages: displacement of electrodes into the pulmonary artery or right atrium results in pacemaker failure; perforation of the right ventricle with loss of pacing and the possibility of hemopericardium and coronary artery perforation is a real hazard (3 of 15 pts.). The use of a modified bipolar catheter with electrodes (1 cm. apart) located 5 cm. proximal to the catheter tip allows positioning of the catheter tip in the main pulmonary artery. This permits stable ventricular pacemaking while minimizing the risk of ventricular perforation.

\* \* \*

### Clinical Experience with the Transvenous Catheter Pacemaker

Harold S. Marcus, M.D., Richard S. Goodwin, M.S.,  
Joseph M. Ryan, M.D., F. A. C. P., and Charles  
F. Wooley, M.D.

*From Heart Station, University Hospital, Columbus, Ohio, and the  
Department of Medicine, The Ohio State University College  
of Medicine, Columbus, Ohio*

The management of patients with abnormalities of cardiac impulse function and conduction by conventional drug therapy is far from satisfactory. Isoproterenol, for example, is unpredictable in its action in complete heart block and is sometimes the cause of ventricular irritability.

In the past two years we have treated 40 patients with a transvenous dual electrode catheter pacemaker. Twenty-five patients had complete heart block and were paced as part of the management of the Adams-Stokes syndrome and as a temporary measure prior to the implantation of a permanent pacer. In many of these patients the pacer catheter was inserted as an emergency procedure and in several instances was considered lifesaving. No permanent pacemaker units were implanted without prior insertion of a catheter pacemaker.

Five patients required pacing as a result of myocardial infarction. Ten were paced for varying reasons (two myocarditis, two drug intoxication with digitalis or quinidine, two with chronic asymptomatic heart block paced electively during non-cardiac surgery, four miscellaneous).

Pacing was achieved in each of the 40 patients, and continued for periods of several hours to two weeks. Direct control of the heart rate was obtained without mechanical complications and without the vagaries of drug action.

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### Pancreatic Scanning: The Use of Morphine To Increase Concentration of Selenium<sup>75</sup>-Methionine

Antonio Rodriguez-Antunez, M.D., Francis J. Owens,  
M.D., and B. H. Sullivan, Jr., M.D., F. A. C. P

*From the Department of Radiation Therapy and Isotopes and the  
Department of Gastroenterology, The Cleveland Clinic  
Foundation, Cleveland, Ohio.*

The selective accumulation of Se<sup>75</sup>-methionine in the pancreas is being utilized in the study of patients

suspected of having pancreatic lesions. The Se<sup>75</sup>-methionine is injected intravenously into the patient after pancreatic stimulation with a high-protein, high-carbohydrate, low-fat meal. To achieve greater concentration of the radioactive selenomethionine in the pancreas the sphincter of Oddi is constricted by an intramuscular injection of morphine sulfate. Scanning is begun about one-half hour after the injection of the Se<sup>75</sup>-methionine, and scintigrams are then prepared by standard methods.

Of 24 patients, 12 each had a pancreas normal in appearance on the scintigram, and no operation was performed: in 12 the scintigrams suggested abnormalities, 8 were diagnosed as carcinoma of the pancreas, proved correct at operation; 4 were diagnosed as carcinoma, but at operation the diagnosis was proved incorrect. Failure of the pancreas to visualize is interpreted as evidence of disease, but lesions have not always been substantiated at laparotomy.

This method of diagnosing pancreatic disease is undergoing further study and refinement. It is believed that this communication will stimulate interest in its development.

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### "Suppressive" Chemotherapy in Bronchogenic Carcinoma — A Randomized Prospective Clinical Trial

Thomas L. Wright, M.D., H. Horwitz, M.D.,  
Harold Perry, M.D., and Charles Barrett, M.D.

*From the Departments of Medicine and Radiology and the  
Radioisotope Laboratory, University of Cincinnati College  
of Medicine, Cincinnati, Ohio*

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### Nitrogen Mustard in the Treatment Of Chronic Ulcerative Colitis And Regional Enteritis

Eugene I. Winkelman, M.D., (Associate), and  
Charles H. Brown, M.D., F.A.C.P.

*From the Department of Gastroenterology, The Cleveland Clinic  
Foundation, Cleveland, Ohio*

Treatment of various non-neoplastic diseases, particularly those considered "auto immune disease," has been noted. The results of therapy with nitrogen mustard in 26 patients, 11 with chronic ulcerative colitis and 15 with regional enteritis, is herein reported. All with colitis had the typical proctosigmoidoscopic and roentgen findings whereas 13 of those with enteritis were diagnosed surgically. The remaining two presented the classical clinical and radiological picture.

All cases were selected for their refractoriness to an intensive medical regimen supervised by one of the authors. Results were considered satisfactory only if the patient resumed a normal life with usual bowel habits, laboratory values returned to normal, proctosigmoidoscopic examination showed no activity, and any fistulous tracts closed.

Eight with ulcerative colitis have had a remission



for six months or more, one required emergency surgery, one died of a myocardial infarction three weeks after therapy, and the last case is indeterminate. Nine with regional enteritis had a good result although five had had previous definitive surgery. Six were rated unsatisfactory with three requiring resection or bypass, two continuing with minimally altered symptoms, and one dying with fulminant ileocolitis. One in each group healed a fistulous tract.

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### The Mechanism of Formation of a "Marker" Chromosome in a Transplantable Spontaneous Chloroleukemia In the Wistar Rat

Thomas L. Wright, M. D., Phillip D. Pahner, B.S., Ben I. Friedman, M. D., and John J. Will, M. D.

*From Hematology and Radioisotope Laboratories, University of Cincinnati College of Medicine, Cincinnati, Ohio*

Recently there has been increasing interest in the deviations in the chromosomal number and structure found in the cells of many neoplasms.

Abnormalities in both structure and number of the chromosomes were found in the karyotypes from cells of transplantable spontaneous chloroleukemia in the Wistar rat. Approximately 20 per cent of the cells had a large metacentric "marker" chromosome which was not found in the normal rat karyotype. In addition the chromosomal number in the chloroleukemia cells was increased over the normal chromosomal number of 42. The number was variable with a range of from 43 to 55 chromosomes. The chloroleukemia cells could be separated into two groups on the basis of the presence or absence of a metacentric chromosome. In both populations the variation in chromosomal number approximated a normal distribution. Those cells containing the metacentric chromosome had a mean chromosomal number of 49 while the mean chromosomal number in cells not containing a metacentric chromosome was 50.

From these data it is proposed that the metacentric chromosome results from the fusion of two acrocentric chromosomes. Of the several mechanisms which might account for the development of metacentric chromosomes, fusion is the only mechanism that would explain the associated reduction in chromosome number.

\* \* \*

### Sternberg-Reed Cells in the Peripheral Blood of Patients with Hodgkin's Disease

Bertha A. Bouroncle, M. D.

*From the Department of Medicine, The Ohio State University Hospitals, Columbus, Ohio*

The presence of Sternberg-Reed cells in the smears of peripheral blood on routine examination is a rarity.

Our present report is a study of the incidence of

Sternberg-Reed cells in the peripheral blood of patients with Hodgkin's disease. We have used, in our study, a modification of the technique of silicone flotation described by S. H. Seal. A total of 130 patients with confirmed Hodgkin's disease were studied by means of this technique. A total of 1,006 determinations have been performed with from one to 47 tests having been made on each patient, and the samples obtained at different stages of their illness.

Our observations indicate that typical Sternberg-Reed cells or "suspect" Sternberg-Reed cells were found in the peripheral blood in 16, or 12 per cent of patients with Hodgkin's disease. They were found only at a very advanced stage and most frequently within three months prior to death.

Other abnormal cells classified as atypical large mononuclear, binucleated and increased mitotic cells were found earlier in the disease in 50, or 38 per cent of patients with Hodgkin's disease.

Our observations indicate that patients with Hodgkin's disease may exhibit Sternberg-Reed cells or "suspect" Sternberg-Reed cells in their peripheral blood in the very advanced stage of their illness. Its contribution to the diagnosis is insignificant. Its presence can be considered of prognostic value. Its demonstration supports the haematogenous metastasis of the disease.

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### The Response of Patients with Hyperglycemia to Intravenously Administered Glucose

Margaret J. Albrink, M. D., and Paul C. Davidson, M. D.

*From the Department of Medicine, West Virginia University School of Medicine and Medical Center, Morgantown, West Virginia*

Intravenous glucose tolerance tests were carried out in 38 patients with a wide range of plasma triglyceride concentrations. Included were normal subjects and patients with obesity, atherosclerosis, thyroid disease, previously undiagnosed mild diabetes and clinically manifest diabetes. Age ranged from 17 to 73 and triglyceride fatty acid concentration (TGFA) from 2.4 to 17 mEq/L (upper limit of normal 5.4 mEq/L).

Plasma sugars and nonesterified fatty acids (NEFA) were measured before and at intervals for six hours after the intravenous administration of 2.5 Gm. glucose. Serum cholesterol and triglycerides were measured in the fasting sample. The disappearance rate, K, for the rapid phase of glucose disappearance was calculated from the plasma sugar concentrations between 20 and 60 minutes after the administration of glucose.

TGFA concentration showed a significant positive correlation with the fasting blood sugar concentration and with the lowest blood sugar during the reactive hypoglycemic phase expressed both as absolute concentration and as per cent of the highest blood sugar concentration. TGFA concentration was negatively

correlated with the constant, K, defining the rapid phase of glucose disappearance. TGFA concentration was almost significantly related to the lowest NEFA concentration and the time required for achieving the lowest NEFA.

There was no correlation between any of the parameters measured and age or plasma serum cholesterol concentration.

In summary, TGFA elevation signified slow disappearance rate of glucose from the blood stream, diminished or absent reactive hypoglycemia, and impaired response of NEFA to glucose administration, all indicative of insulin resistance. It is suggested that hyperglyceridemia is a manifestation of the body's defenses against the hyperinsulinism of early diabetes or prediabetes.

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### Lipoatrophic Diabetes

George J. Hamwi, M. D., F. A. C. P., Fred A. Kruger, M. D., Michael J. Eymontt, M. D., Grant Gwinup, M. D., and Richard Byron, M. D.

*From the Department of Medicine, Division of Endocrinology and Metabolism, The Ohio State University Hospitals, Columbus, Ohio*

Studies of a fifteen-year-old white female with classical lipoatrophic diabetes exhibiting complete loss of subcutaneous fat, xanthomatosis, hyperlipemia, hyperglycemia, glycosuria, hypermetabolism, hepatosplenomegaly, and non-ketonic insulin resistance will be presented. The following have been observed: (1) increased periodicity of food intake diminished hyperlipemia, and hyperglycemia; (2) normal plasma insulin and growth hormone; (3) potent lipid mobilizing, as well as definite anti-insulin activity in urine; (4) stimulation of glucose oxidation by large insulin doses; (5) absence of the typical signet-cell type adult fat cells, but presence of immature fat cells, in the subcutaneous tissue by electron microscopy; (6) renal changes characteristic of Kimmelstiel-Wilson's Disease. The last finding is of particular interest since this type of diabetes is in most respects unlike typical genetic diabetes mellitus. Although the etiology of lipoatrophic diabetes remains obscure, the available evidence favors the over-production of a humoral substance which either antagonizes the lipogenic activity of insulin on adipose tissue cells, or overwhelms the lipid storage capacity of the latter by continually stimulating lipolysis so that the normal fat synthesizing and storage cells are not seen by electron microscopy.

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### The Relation of Insulin Responsiveness To Plasma Triglyceride Levels

Paul C. Davidson, M. D., and Margaret J. Albrink, M. D.

*From the Department of Medicine, West Virginia University, Morgantown, West Virginia*

The role of insulin resistance in the previously demonstrated relation of impaired carbohydrate me-

tabolism to hyperglyceridemia was studied. The response of the plasma free fatty acids and the blood glucose to intravenous insulin injections was measured in 8 normal persons, 9 obese persons, 12 persons with fasting hyperglycemia, and 19 persons with hyperglyceridemia.

A significant correlation at the  $t < 0.05$  level was found between the fasting triglyceride level and the degree of responsiveness to insulin. The latter could be quantitated either by the rapidity with which the blood glucose reached one-half its initial level or by the ratio of the lowest level to the initial blood glucose level. A significant correlation,  $t < 0.02$ , was observed between blood glucose levels and the lowest free fatty acid level following the insulin injection. The latter generally occurred at 30 or 45 minutes.

The availability of glucose to the adipose tissue has been shown to be inversely related to the free fatty acid levels. It is postulated that an impaired response to insulin allows more fatty acids to be released from the adipose tissue. These are then available to the liver for the synthesis of triglyceride-containing lipoprotein. This in turn results in increased plasma triglyceride levels.

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### Diabetes in Hyperthyroidism

Kenneth Kreines, M. D., Marian Jett, R. N., and Harvey C. Knowles, Jr., M. D.

*From the Department of Internal Medicine, Cincinnati General Hospital and The University of Cincinnati College of Medicine, Cincinnati, Ohio*

Observations were made of glucose tolerance and family and obstetrical histories in 51 sequentially diagnosed hyperthyroid patients. Seventeen patients (33.3 per cent) knew of diabetes in their families, and 8 of 36 women (22.2 per cent) with term pregnancies had delivered infants weighing 9 lbs. or more. These prevalences are greater than those described in the general population.

Six patients had previously diagnosed diabetes, and glucose tolerance tests (GTT's) repeated in the euthyroid state remained diabetic (criteria of Fajans and Conn). Twenty-two patients without previously diagnosed diabetes were found to have diabetic GTT's. Of 17 repeated tests, 6 were diabetic, 4 were suspicious (abnormal but not diagnostic of diabetes), and 7 were normal. Of 8 hyperthyroid patients with suspicious GTT's, tests were repeated in 5 and found to be diabetic in one, suspicious in one, and normal in 3. Of 15 patients with normal GTT's, tests were repeated in 13 and found to be normal in 10, suspicious in 2, and diabetic in one.

The findings suggest that diabetes may be more



prevalent in hyperthyroid patients than suspected previously and may be genetic in origin.

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### The Results of $I^{131}$ Treatment of Graves' Disease in Thirty-Two Children Under 16 Years of Age

O. Peter Schumacher, M. D., and  
George Crile, Jr., M. D.

*From the Department of Endocrinology and the Department of Surgery, The Cleveland Clinic Foundation, Cleveland, Ohio*

Between 1949 and 1961 32 children (between the ages of 7 and 15 years) with Graves' disease were treated with  $I^{131}$ . Thirty patients have been treated and followed to date. Sixteen patients have been followed five or more years and five patients have been followed 10 years or longer. Doses of  $I^{131}$  ranged from one treatment of 2 mc. to three treatments totalling 39 mc. (average of 9.6 mc.).

In the 30 patients, hyperthyroidism was controlled and did not recur. Clinical hypothyroidism required treatment in four patients. Thirteen patients who were euthyroid clinically received thyroid therapy because of low normal basal metabolic rates or low tracer values. All children have been examined in the last year and no palpable goiters or nodules have developed.

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### Adrenal Cortical Function During Starvation in Obese Patients

S. H. Schachner, M. D., R. G. Wieland, M. D. (Associate), F. A. Kruger, M. D., D. E. Maynard, M. D., and G. J. Hamwi, M. D., F. A. C. P.

*From the Department of Medicine, Division of Endocrinology and Metabolism, The Ohio State University Hospitals, Columbus, Ohio*

Increased adrenal cortical function has been found frequently in association with obesity with a return to normal cortisol production levels following weight control. Short periods of starvation have become popular for the treatment of obese states. Since gluconeogenesis and the elevation of fatty acids that occur during starvation might be attributed to increased cortisol secretion, the effect of starvation on adrenal cortical function in grossly obese patients, placed on a total fast for 10 to 14 days, was studied.

Contrary to expectation plasma cortisol values did not become elevated and urinary excretion of 17-OHCS and 17-KS fell moderately during the fasting period with the 17-KS showing, in general, a greater reduction. Urinary cortisol excretion diminished slightly. Plasma free fatty acid concentration increased during starvation as expected.

It was concluded that gluconeogenesis, fatty acid mobilization and ketone body production that occur during fasting are not dependent upon an increased adrenal cortical secretion.

### Two Hour ACTH Test for Adrenal Insufficiency

Thomas Riley, M. D., Grant Gwinup, M. D., and  
George J. Hamwi, M. D., F. A. C. P.

*From the Department of Medicine, Division of Endocrinology and Metabolism, The Ohio State University Hospitals, Columbus, Ohio*

The use of the 48 hour ACTH test to define the integrity of the human adrenal gland has universal acceptance. The time required for the collection of base line and post-stimulation urinary 17-OH steroids is cumbersome.

We propose a quick test for the assessment of adrenal cortical insufficiency. Urinary cortisol is measured on a base line random specimen. Twenty-five units of aqueous ACTH is given intramuscularly and urinary cortisol is determined on a two hour postinjection specimen. The values are expressed in terms of micrograms of cortisol per milligram of creatinine.

A group of 50 normal subjects and groups of five subjects each with Addison's disease, cirrhosis, uremia, and thyrotoxicosis (endogenous and exogenous) were tested.

Normal subjects showed an average sixfold increase over base line values (range: 2.5 to 15-fold increase). The subjects with Addison's disease showed no increase over the base line values. The response of subjects with cirrhosis, uremia, and thyrotoxicosis will also be presented.

This simplified method affords us a practical outpatient screening procedure for the detection of adrenal insufficiency.

\* \* \*

### Low-Dosage Glucocorticoid Therapy

William McK. Jefferies, M. D., F. A. C. P.

*From the Department of Medicine, Western Reserve University School of Medicine, Cleveland, Ohio*

Therapeutic effectiveness of glucocorticoids in clinical disorders has been thought to depend upon production of a state of hypercorticism with its accompanying hazards. As experience has accumulated, it has become apparent that doses of cortisone acetate too small to produce hypercorticism may have clinically beneficial effects in arthritic and allergic diseases as well as in some cases of ovarian dysfunction, hirsutism, acne, and chronic cystic mastitis.

In studies of the effects of low-dosage glucocorticoid therapy in over 200 patients with various disorders for periods up to eight years, it has been found that (1) these doses can significantly affect steroid metabolism, as measured by urinary excretion of steroid fractions, without changing hydrocortisone levels, (2) administration at relatively frequent intervals is necessary to produce optimum effect, (3) stabilization of a new pattern of steroid excretion may require several weeks, and (4) prolonged ad-

ministration has caused no side effects or impairment of response to stress, ACTH, or metopirone.

These observations suggest that current concepts of the mechanism of steroid effect upon disease processes may require revision, and they indicate that this type of steroid therapy is remarkably free of undesirable side effects.

\* \* \*

#### **Pancreatic Collagenase Therapy for Severe Progressive Systemic Sclerosis: Effect on Skin and on Hydroxyproline Content in Urine**

Constantine L. Nellas, M. D., Nevil'e Crawford, Ph. D., and Arthur L. Scherbel, M. D., F. A. C. P.

*From the Department of Rheumatic Disease and Division of Research, The Cleveland Clinic Foundation, Cleveland, Ohio*

Since the protein collagen contains almost all of the hydroxyproline in the body, the measurement of this amino acid can be used to estimate the collagen content of tissue and its urinary output may serve as an index of metabolic degradation of this protein.

A 39 year old man with severe progressive systemic sclerosis was treated with AL-0534, a mammalian pancreatic extract containing collagenase. During the first two weeks of treatment he exhibited both subjective and objective signs of improvement. After six weeks, his improvement ceased and there was some regression. Serial determinations of the urinary hydroxyproline output and the hydroxyproline content of skin biopsies were made.

The results from this study show that during treatment the urinary hydroxyproline output increased from levels slightly higher than the accepted normal range (15-40 mg. per day) to values as high as 200-300 mg. per day. Initially these increased urine outputs were accompanied by a fall in the skin hydroxyproline content at various sites but later in the treatment the skin content increased again although not quite to the pretreatment levels. A comparison of the molar ratios of hydroxyproline and proline in skin and urine during treatment suggests that some selective 'in vivo' enzymatic breakdown of collagen was taking place.

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**PHILANTHROPY.**—It was a time to dust off ancient platitudes about virtues of thrift and loyalty: A quiet little Canadian elementary school dropout and former carnival worker had remembered his University of Cincinnati employers in his will with a \$17,000 savings account.

Thomas Evans Hughes, who had no family but many loyal co-workers, had never earned more than \$62.66 per week in his 35 years as an attendant in the U. C. College of Medicine Department of Radiology at Cincinnati General Hospital.

U. C. radiologists on March 12 unveiled a plaque naming the x-ray suite in the hospital's new Emergency Unit after "Tommy."

The plaque read "Tommy Hughes Memorial X-Ray Unit." Dr. Benjamin Felson, professor and director of the U. C. department, was in charge of the ceremonies.

With the \$17,000 as nucleus, U. C. has set up a Radiological Endowment Fund for department improvements. To this fund recently Dr. Harold G. Reineke gave proceeds from Series E bonds left to him by Tommy.

Dr. Reineke, U. C. clinical professor of radiology and former director of the department at the hospital, recalled loyal Tommy had a sixth grade education, ran away from his home in Winnipeg at an early age to work with a carnival, and was stranded in Oklahoma when it went broke. "He worked his way to Cincinnati and after a series of menial jobs he finally got a job at General Hospital as an orderly," Dr. Reineke said. This was in the early 1920's. In 1925 Tommy was transferred to the x-ray department where he worked until health forced him to retire in 1960.

Tommy's amazing photographic memory for numbers and his dedication made him a stand-out worker. "He was one of the most valuable employees in the department during the years I headed the section," Dr. Reineke said. "He continued there, doing everything in the place except the medical work. He had an uncanny ability to find lost x-ray films, to remember names and faces. He finally had to retire because of pulmonary emphysema, which made all of us sad.

"At his death we all felt we had lost a valued friend. Imagine our surprise at finding a bank account running into the thousands of dollars . . ." — University of Cincinnati Medical Center: *News Release*, March 12, 1965.



# Congenital Absence of the Gallbladder

MANUEL X. NETO, M.D., and HENRY W. BROWN, M.D.

CONGENITAL abnormalities of the biliary system have been reported with increasing frequency during the past decades, probably due to the greater number of operations being performed upon the gallbladder. Familiarity with the congenital anomalies of the gallbladder and extrabiliary ducts is extremely important to assure proper diagnosis and treatment in this system. In general, the incidence of this anomaly, as reported in the world literature varies between 0.035 and 0.065 per cent. Monroe and Ragen<sup>2</sup> in reviewing 35,626 autopsies, found an incidence of congenital absence of gallbladders in 33 cases, or 0.9 per cent. Tallmadge<sup>3</sup> found the condition to be present in 0.065 per cent of the cases. Congenital anomalies of the biliary tract are reported to be present in 10 per cent of all persons. Most of them, however, are of no clinical significance. Mentzer<sup>4</sup> in 1929, collected 50 cases of congenital absence of the gallbladder reported in the literature, and Seifert<sup>6</sup> in 1963, reported five more cases, elevating the number to 144.

Abnormalities of the biliary tree and gallbladder are not infrequent in animals. Mentzer<sup>4,5</sup> has found 17 species of fish, nine species of birds, and 26 species of mammals normally devoid of a gallbladder. Some animals develop a gallbladder in embryonal life that disappears during later development. This phenomenon has been reported in the Petromyzon, and in the pigeon.

## Embryology of the Biliary Tree

Beginning about the second week of embryonal life, a thickened area of entoderm develops in the region of the junction of the foregut, and the yolk sac. This area soon forms a sacculatation, which then further differentiates into a cranial and a caudal anlage (Fig. 1). The cranial portion divides into a right and left mass, and forces its way ventrally into the mesenchymal tissue of the septum transversum to form the liver. The caudal portion of the anlage is the forerunner of the gallbladder and cystic duct. These diverticulae are originally tubular, but later become solid throughout. At the 7 millimeter stage, a distinct cystic duct can be detected. One, or possibly two, ventral evaginations from the entoderm are the anlage of the head of the pancreas which appear at about the same time as the liver.

## The Authors

- Dr. Neto, Cleveland, is Chief Resident in Surgery, Huron Road Hospital.
- Dr. Brown, Cleveland, is Chief, Division of General Surgery, Huron Road Hospital.

This would explain a few reported cases of associated defects in the pancreas, such as absence of the head of this organ.<sup>7</sup>

In the seventh week, the lumen becomes reestablished within the common bile duct and gallbladder, and bile begins to be secreted within three months of fetal life. If vacuolization of the biliary system is incomplete, the various abnormalities, such as phrygian cap, aberrant valves of Heister, diverticula or abnormalities of the septum can occur.<sup>14</sup> Thus two theories have been advanced to explain the congenital absence of the gallbladder and cystic duct, (a) failure of recanalization of the caudal portion of the primitive anlage during the 5 millimeter stage when the lumen is not reestablished, (b) when the caudal

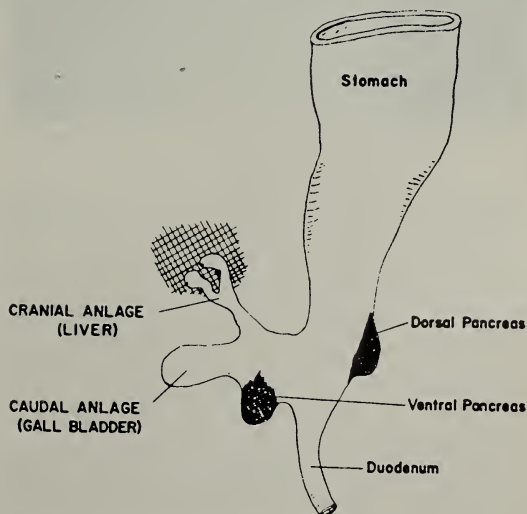


Fig. 1.—Development of the gallbladder (7 mm. embryo).

FIG. 1. (Reproduced with permission from the CANADIAN JOURNAL OF SURGERY, 5:446, 1962.

portion of the original hepatic sacculation, which is the forerunner of the gallbladder, fails to grow.<sup>8,9</sup>

Gallbladder agenesis has been observed in persons of different ages, the youngest being 21 months, and the oldest 83 years.<sup>1</sup> This anomaly may be accompanied by other defects, especially when it is found in infants. However, most of the cases reported in adults do not have associated anomalies. Kobacker<sup>10</sup> called attention to the possibility of this anomaly being of an hereditary nature by reporting the cases of two sisters with agenesis of the gallbladder.

### Clinical Features

The effect of absence of the gallbladder in biliary function is not settled. Of the cases reported in the literature, almost half were discovered at operations



FIG. 2. *Operative cholangiogram showing complete absence of the gallbladder and cystic duct.*

which were performed because of signs and symptoms of biliary tract disease.<sup>12</sup> Dixon and Lichtman<sup>11</sup> reviewed 60 cases reported from the literature, and found 35 patients, or 58 per cent, to have symptoms suggestive of cholecystic disease, and 29 patients, or 48 per cent, to have jaundice. Gallstones were found in the common bile duct or in the hepatic ducts, in 16 patients, or 27 per cent. In about 30 to 50 per cent of the patients with agenesis of the gallbladder who were operated upon, the common bile duct was found to be dilated.<sup>13</sup> In the patients over the age of 45 years, 73 per cent had symptoms of gallbladder disease.

When operating for gallbladder disease, if the surgeon does not find the organ, he should establish, first, whether the absence of the gallbladder is only

apparent, or real. In the former instance, the gallbladder may be situated (a) within the liver lobes, (b) in a transverse position, (c) between the blades of the falciform ligament, (d) behind the peritoneum and (e) below the inferior surface of the left lobe of the liver.<sup>14</sup>

Common duct exploration and operative cholangiogram is imperative in all cases of congenital absence of the gallbladder and cystic duct. Operative cholangiogram is not only important to rule out the possibility of common duct stones, but also enables one to make the diagnosis of agenesis of the organ (Fig. 2). Needling of the liver is not only harmful but not diagnostic, since bile found on aspiration may come from a large bile duct or from a large intrahepatic gallbladder. Patients with gallbladder agenesis and with stones present in the common bile duct have adequate pathologic findings to explain their symptoms. In the group without common duct stones the symptomatology is difficult to explain. The only abnormal finding at the time of exploration is a dilated common duct.

### Case Reports

Case 1. The patient was a 68 year old white woman admitted to this hospital with a history of having repeated attacks for many years, of right upper quadrant pain radiating to the back and right upper shoulder blade. At times the pain was accompanied by nausea and vomiting. Previously this patient had cholecystograms which revealed a nonfunctioning gallbladder. Physical examination revealed blood pressure of 130/80, pulse rate 80 per minute, respiratory rate 16/min. The abdomen was moderately obese with tenderness in the right upper quadrant, the liver appeared to be enlarged 2 cms. below the right costal margin. The remainder of the physical examination was entirely negative. Routine laboratory studies were within normal limits.

In October 1947 the patient was explored with the preoperative diagnosis of chronic cholecystitis and cholelithiasis. Examination of the right upper quadrant revealed complete absence of the gallbladder and cystic duct. Numerous adhesions were found around the porta hepatis, which were lysed. The common bile duct was not found to be enlarged. No further exploration was carried out. The patient had an uneventful postoperative course.

Case 2. This 34 year old white woman entered the hospital because of epigastric pain of a crampy nature, present for one year. The pain was relieved by food at times, and did not radiate to the back or shoulder. No history of fatty food intolerance, or jaundice. *Physical Examination:* Blood pressure 140/90, pulse rate 84, respiratory rate 20 per minute. Examination of the abdomen was entirely negative, as well as the remainder of the physical examination. Laboratory studies were within normal limits. Oral cholecystogram, on two occasions, failed to visualize the gallbladder. Upper gastrointestinal series roentgenogram was negative.

With the preoperative diagnosis of nonfunctioning gallbladder, the abdomen was explored through a right subcostal incision. A general exploration of the abdomen was entirely negative. On searching the right upper quadrant, no gallbladder or cystic duct could be seen. Transoperative cholangiogram was then carried out which confirmed the absence of the gallbladder and cystic duct. The common bile duct was not dilated. This patient had a normal postoperative course, and has remained well.

Case 3. The patient was a 45 year old white man admitted to this hospital with a history of sharp chest pain, of about 10 to 12 months duration, radiating to both shoulders. There was also occasional shortness of breath and sweating, which was not relieved by nitroglycerin. One year prior



to admission, the patient had a myocardial infarction and since then he had continued on anticoagulant therapy. There was no nausea or vomiting, and no history of food intolerance was reported. No jaundice. *Physical Examination:* Blood pressure 200/120, pulse rate 108, respiratory rate 16 per minute. The abdomen did not reveal any tenderness, the liver and spleen were not palpable. Oral cholecystogram was performed on two occasions, and the gallbladder could not be visualized. Laboratory findings were within normal limits. Upper and lower gastrointestinal roentgenograms were reported as being normal.

Operation was advised and on November 3, 1961, the abdomen was explored through a right subcostal incision. On exploration of the right upper quadrant, the gallbladder and cystic duct were found to be absent. A Kocher maneuver was carried out and the common bile duct explored. No stones were found and the duct was of normal size. Operative cholangiogram was performed, which disclosed good visualization of the duct system, with normal drainage into the duodenum. The immediate postoperative course was uneventful, and the patient was discharged on the tenth postoperative day in good condition.

### Comments

Of the three patients herein reported, with congenital absence of the gallbladder, only one did not have typical signs and symptoms suggestive of chronic cholelithiasis, and cholecystitis. No stones could be felt or seen in the two patients in which operative cholangiogram was carried out, nor was the common bile duct dilated. The association of pancreatitis found in 6 per cent of the cases of congenital absence of the gallbladder could perhaps explain the symptoms found in some of these patients.<sup>9</sup> Spasticity of the sphincter of Oddi has also been blamed as causing the symptoms found in these patients, and perhaps a sphincterotomy might be of some value in such cases. The congenital absence of the gallbladder is certainly compatible with nor-

mal function of the biliary system, and in most instances of the reported cases in adults, were not accompanied by any other congenital malformation elsewhere, or in the biliary tree.

### Summary

Three cases of congenital absence of the gallbladder and cystic duct are reported. Some aspects of the embryology responsible for this congenital anomaly are reviewed. In no instance of this rare congenital anomaly herein reported, was there jaundice, a dilated common duct, or stones found at operation. The role of operative cholangiogram in verifying the absence of the gallbladder is also emphasized.

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**MANAGEMENT OF DIABETES.** — The characteristic of the rapid phase (10 to 20 minutes) of plasma disappearance of I<sup>131</sup>-labeled insulin was studied in 45 diabetic patients. The half-life of the disappearance curve was 14.6 minutes for diabetic patients not treated with insulin, 23.5 minutes for stable insulin-treated patients and 58.6 minutes for patients with "brittle" diabetes. Patients underwent reregulation in the hospital. It was found that patients with the longest half-life for disappearance of labeled insulin (740 minutes) obtained optimal regulation on regular insulin whereas those with a half-life in the range of 20 to 40 minutes were best regulated with mixtures of isophane and regular insulin. Those with an insulin half-life of less than 20 minutes were best regulated on isophane insulin alone.

The disappearance test serves as a convenient guide to management of "brittle" diabetes. — Robert E. Bolinger, M.D., J. Harold Morris, M.D., et al., Kansas City, Kansas, *The New England Journal of Medicine*, 270:767-770, April 9, 1964.

# Synthesis and Release of Renin

## The Role of the Juxtaglomerular Apparatus

JAMES J. SCHELL

**T**IGERSTADT and Bergman first recognized and described some of the properties of renin in 1898. Despite this early account, renin remained unknown to the investigative world until 1938 when it was independently described by a number of investigators. In 1939 Goormaghtigh reported the existence of an arteriolar and tubular complex at the pole of the renal glomerulus which he named the juxtaglomerular apparatus. He described the occurrence of hypertrophy and granulation of the arteriolar component of the juxtaglomerular apparatus with renal ischemia and suggested these changes might represent renin production. On the basis of these observations, he proposed that renin might be the etiologic factor in hypertension.<sup>1</sup> His hypothesis aroused the interest of investigators who felt that renin was going to be the answer to the enigma of hypertension. Consequently this hypothesis acted as the impetus for numerous studies inquiring into the site of renin synthesis and factors which lead to its synthesis and release. It will be the purpose of this paper to review these studies and discuss the role of the juxtaglomerular apparatus in both the synthesis and release of renin.

### The Juxtaglomerular Apparatus

By virtue of their presence at the glomerular pole, any of several cell groups could be concerned with the synthesis and release of renin. Goormaghtigh, following extensive histological evaluation of this region, concluded that the juxtaglomerular apparatus consisted of two distinct cell groups: the juxtaglomerular cells which are found within the wall of the afferent arteriole just before it enters the glomerulus and the corpuscle pseudo-Meissnerien, a compact group of cells in the angle formed by the junction of the afferent and efferent arterioles (see Fig. 1).<sup>2</sup> The latter group of cells has been more popularly referred to as "polkissen cells" (Zimmerman, 1933). Recent electron microscopy studies reveal that, with proper stimulation, the polkissen cell may transform directly into a juxtaglomerular cell.<sup>3</sup> Some investigators feel the macula densa should be included as a component of the juxtaglomerular apparatus because of its intimate relationship with the juxtaglomerular and polkissen cells.<sup>4,5</sup> Electron microscopy studies

### The Author

• Mr. Schell, Columbus, is a Senior Medical Student, The Ohio State University College of Medicine.

appear to justify this inclusion in that the juxtaglomerular cells and the cells of the macula densa are not separated by a basement membrane and intercellular channels connect the two cell types.<sup>6</sup>

### Site of Renin Synthesis

The initial evidence which pointed to the juxtaglomerular cell as the site of renin synthesis consisted of a number of observations compatible with increased secretory activity: increase in the size of the individual juxtaglomerular cell; increase in the number of juxtaglomerular cells; presence of vacuoles within the juxtaglomerular cells; and the observation of other ultrastructure features (e.g. mitochondria and endoplasmic reticulum with prominent ribonucleic acid granules) which are indicative of protein synthesis.<sup>7</sup> The next step was for investigators to develop methods through which they might establish that these observations did in fact represent increased renin secretion.

Pickering and Cook devised an isolation technique which enabled them to demonstrate renin's localization to the vascular pole (proximal end) of the glomerulus.<sup>8</sup> In this study it was shown that the glomeruli could be filled with magnetic iron, filtered, suspended in saline, and then selectively isolated with an electromagnet. By varying the sieve size, the glomeruli could be isolated with or without tubular and arteriolar attachments. Assay showed the glomeruli with attachments contained a greater amount of renin than the naked glomeruli. In a subsequent study, Cook employed microdissection methods to divide the glomeruli into proximal and distal fragments. The proximal fragment with its associated macula densa, polkissen cells, afferent and efferent arterioles was found to be the renin containing portion. No renin was found to be associated with the distal fragment.

Bing and Kazimierczak, through microdissection ex-

Submitted December 14, 1964.



traction studies, confirmed renin's localization to the proximal fragment and further established that renin was localized to the afferent arteriole. Their assays also indicated that in addition to the afferent arteriole, renin appeared to localize to the macula densa. On the basis of these assays, it was their impression that the macula densa was as important as the juxtaglomerular cell for renin production.<sup>4,5</sup>

It remained for Hartroft and her colleagues, using fluorescent antibody techniques, to establish the juxtaglomerular cell as the site of renin synthesis and secretion. In their studies, dogs were immunized with hog renin and the anti-canine globulin was conjugated with fluorescein. Following injection, the antirenin labeled the juxtaglomerular cells of the hog, dog, and rabbit.<sup>9,10</sup> These observations gained further support when embryo studies with fluorescein staining revealed juxtaglomerular cell localization in the fetal pig metanephros and in the fish mesonephros.<sup>11</sup> The fluorescent antibody technique demonstrates that the juxtaglomerular cell and not the macula densa or other structures of the renal cortex is the source of renin. Hartroft feels that Bing and Kazimierzak's conflicting report of renin localization to the macula densa can be explained on the basis that it would be extremely difficult to strip out the macula densa without including some of the closely adhered juxtaglomerular cells.<sup>7</sup>

During the foregoing studies it was observed that in dogs immunized with hog renin, high titers of antirenin were associated with hyperplasia and hypergranularity of the juxtaglomerular cells.<sup>11</sup> In contrast, renin injections into a dog brings about degranulation

EDITORIAL NOTE: Mr. Schell submitted this article to me as his senior paper in medicine. I was struck by the clarity of his discussion of the Role of Juxtaglomerular Apparatus in the Synthesis of Renin. Clarification of this topic has been clouded by claim and counterclaim of disagreeing investigators. Mr. Schell has carefully sifted the conflicting claims to review the current status of information about a process that will some day likely lead to our understanding of the true mechanism of hypertension.

EDWIN J. SMITH, M. D.  
Renal Disease Division  
Department of Medicine  
Ohio State University

increased renin secretion and conversely decreased granularity reflects decreased secretion.

On the basis of the foregoing work, it would appear that Goormaghtigh's original concept is correct in that renin is produced by the juxtaglomerular cell and the polkissen cell should be included as a component of the juxtaglomerular apparatus since it has the ability to transform directly into a juxtaglomerular cell.

#### Regulating Factors of Renin Synthesis And Release

Hypergranularity of juxtaglomerular cells had been noted in sodium deficiency, renal ischemia, and following adrenalectomy.<sup>10</sup> Since hypergranula-

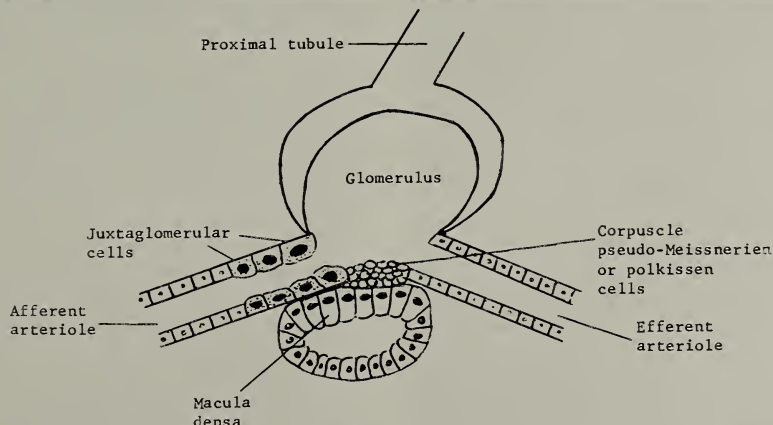


FIGURE 1

of the juxtaglomerular cells.<sup>7</sup> Having established the juxtaglomerular cell as the site of renin synthesis, these observations permit investigators to utilize the degree of juxtaglomerular cell granularity, as well as increases in cell size, number, and so forth, as a reflection of the degree of renin secretion. Thus an increase in juxtaglomerular cell granularity reflects

tion was found to be a reflection of increased renin secretion, investigators became interested in designing studies which would either confirm or refute these observations.

#### The Effect of Sodium Alteration

A relatively simple investigation was to vary the amount of sodium in an animal's diet and study the

effect on juxtaglomerular granularity. The results of this study were extremely rewarding in that it was found that a sodium deficient diet resulted in juxtaglomerular cell hypergranulation and a high sodium diet resulted in juxtaglomerular cell degranulation.<sup>7, 10</sup>

Dunihue was the first to demonstrate that adrenalectomy leads to hypergranulation of the juxtaglomerular cells.<sup>13</sup> The same change was subsequently shown to occur in Addison's disease and in children with the adrenogenital syndrome who die with symptoms of adrenal insufficiency.<sup>12, 10</sup>

Because of the established relationship between the pituitary and adrenal glands, hypophysectomy was performed on rats to determine what effect this might have on renin secretion. This study established that a pituitary factor was not involved in renin secretion in that hypophysectomy neither altered juxtaglomerular cell granularity nor did it prevent their stimulation by sodium.<sup>10</sup>

These observations made it apparent that a direct relationship existed between the juxtaglomerular cells and the adrenal gland. Added insight into this relationship was realized when the effects of dietary sodium alteration on the adrenal gland were reviewed. In this earlier investigation, Deane had established that sodium deficiency produced hypertrophy and sodium excess led to atrophy of the zona glomerulosa.<sup>15</sup> Therefore, dietary sodium alteration produced parallel results in the zona glomerulosa and the juxtaglomerular cells. This parallel response prompted inquiry into the relationship between the adrenocorticosteroids and renin secretion.

Administration of desoxycorticosterone acetate to the adrenalectomized rat was found to reverse juxtaglomerular cell hypergranularity and administration prior to adrenalectomy prevented hypergranularity.<sup>13, 14</sup> Since desoxycorticosterone acetate has a potent salt retaining effect, the study was repeated utilizing sodium administration in place of desoxycorticosterone acetate. The expected results were obtained in that sodium administration was found to prevent the development of juxtaglomerular cell hypergranularity. Further, in the normal animal a sodium deficient diet plus desoxycorticosterone acetate resulted in no change in juxtaglomerular cell granularity whereas a sodium excess diet plus desoxycorticosterone acetate led to marked juxtaglomerular cell degranulation.<sup>7, 10, 13-15</sup> From this line of investigation, it was apparent that the juxtaglomerular cell alteration with adrenal insufficiency was a reflection of sodium deficiency as evidenced by its failure to occur with the administration of either sodium or desoxycorticosterone acetate. As a result of these studies, sodium was implicated as an important factor in regulating juxtaglomerular cell activity. This concept was further strengthened when it was demonstrated that chlorothiazide administration resulted in increased juxtaglomerular cell granularity and increased plasma renin levels.<sup>16</sup>

#### The Effect of Potassium Alteration

The observation of Deane that a high potassium intake produces the same histological changes in the zona glomerulosa as does a low sodium intake prompted Hartroft and colleagues to study the effect of potassium on the juxtaglomerular cells. Because of the parallel correlation referred to above, it was expected that the juxtaglomerular cells would respond to variations in potassium intake. However, the juxtaglomerular cells in rats remained unaltered despite dietary deficiency or excess of potassium, although Deane's observations concerning the adrenal were confirmed. In man the same situation probably exists since in conditions with a combination of hypokalemia and hyponatremia, the juxtaglomerular cells respond as though hyponatremia alone had been present.<sup>7, 10, 15, 17</sup>

#### The Effect of Renal Perfusion Alteration

Numerous investigators have evaluated the juxtaglomerular cell hypergranularity which occurs with renal ischemia.<sup>7, 16, 18-22</sup> Through the classical Goldblatt procedure, i. e., clipping the renal artery, the granularity of the ischemic kidney is observed to double, whereas the contralateral nonischemic kidney is observed to undergo marked degranulation. Early removal of the clip results in juxtaglomerular cell granularity returning to normal bilaterally. This same effect is seen in man with unilateral renal hypertension due to a narrowed renal artery or in cases of acute narrowing of the aorta above the renal arteries.<sup>19, 20, 23</sup> Lowering the blood pressure through hydralazine injections, hemorrhage, or cellophane perinephritis corroborated the foregoing observation that lowered renal perfusion resulted in increased juxtaglomerular cell granularity and increased renin secretion.<sup>10, 24</sup>

In a sense, investigators had been studying the effects of increased blood pressures in the Goldblatt animals since, although the blood pressure decreased distal to the site of arterial clipping, the increased renin secretion by the ischemic kidney led to elevated blood pressure in the contralateral renal artery and here the juxtaglomerular cell granularity was observed to be decreased. Thus this procedure enabled observation of the effects of elevated and lowered blood pressure in the same animal. Corroboration of the effects of increased perfusion was realized through the following studies. In 1955, Hartroft and Hartroft showed that renal arterial pressure elevation through naphazoline injections in rats resulted in the depression of juxtaglomerular cell granularity.<sup>25</sup> Tobian and colleagues attacked the problem directly and, through their well controlled perfusion studies, demonstrated that raising the renal artery perfusion pressure resulted in a distinct lowering of the juxtaglomerular cell granularity.<sup>26</sup>

From these studies, two distinct factors had been implicated in the regulation of juxtaglomerular cell activity, namely, sodium and renal arterial blood flow. However, contradiction as to the importance of so-



dium as a regulatory factor appeared to arise when it was observed that congestive heart failure with edema, ascites, and other sodium retention states produced an increase in juxtaglomerular cell granularity.<sup>18,19,27,28</sup> Further investigation became necessary, not only to clarify the role of sodium as a regulatory factor, but also to gain insight as to how both a decrease in sodium and a decrease in renal blood flow could lead to an increase in renin secretion.

#### The Effect of Sodium Retention States

Experimentally Davis and colleagues have shown that constriction of the thoracic vena cava in dogs will lead to ascites and an increase in the juxtaglomerular cell granularity.<sup>29</sup> In this sodium retention syndrome, the blood tends to dam up behind the caval constriction and the ascites is produced by an increased transudation of fluid into the peritoneal cavity. With transudation, the plasma volume is secondarily diminished.

Congestive heart failure can be produced in the dog by creating an A-V fistula. In this animal the congestive heart failure leads to a pronounced increase in the juxtaglomerular cell granularity.<sup>18,19</sup> In man, Merrill and colleagues have reported that patients with congestive heart failure have increased amounts of renin in their renal venous blood.<sup>30</sup> In the ordinary type of congestive heart failure, the output of the left ventricle is less than normal during exertion and, in some cases, even at rest. The blood dams up behind the failing ventricle with a resulting rise in the capillary hydrostatic pressure and an increased tendency for transudation of fluid out of the vascular bed. The lowered cardiac output, the damming of the blood behind the failing ventricle, and the increased transudation of fluid out of the vascular bed all tend to decrease the arterial volume.<sup>18</sup>

Tobian, Perry, and Mork produced the nephrotic syndrome in rats by the subcutaneous injections of aminonucleoside over an 18 day period. Following sacrifice, the rats exhibited widely varying degrees of sodium retention and ascites. Dividing the animals into groups revealed the greater the degree of ascites, the greater the juxtaglomerular cell granularity. In experimental nephrosis the leakage of albumin through the glomeruli leads to a lowered serum albumin concentration with the result that the capillary hydrostatic pressure exceeds the plasma colloid osmotic pressure. In accordance with Starling's Law, this produces a transudation of fluid out of the vascular bed which, in turn, leads to a lowered plasma volume.<sup>18</sup> The same mechanism would explain the increased juxtaglomerular cell granularity in liver disease in man except the initiating factor would be decreased albumin production instead of increased albumin loss.<sup>16</sup>

In each of the foregoing situations a pathologic state led to a decreased plasma volume and an increase in the juxtaglomerular cell granularity. These findings are not surprising when one stops to con-

sider that renal artery constriction also leads to a decreased renal arterial volume distal to the site of constriction and an increase in the juxtaglomerular cell granularity. Further, the effect of sodium deficient diet may operate in a similar manner. Murphy, in his dietary studies, established that a lowered intake of sodium tends to decrease the blood volume.<sup>31</sup> It would seem probable that this decrease is shared by the various compartments of the vascular bed and, accordingly, the blood in the afferent arteriole would be diminished.<sup>18</sup> Therefore, it would appear that both renal artery constriction and sodium deficiency could act through the common mechanism of decreased renal arterial volume to effect an increase in renin secretion.

#### The Effect of Increased Plasma Volume

Recent investigation of the extracellular fluid and plasma volume changes following constriction of the renal artery offers further support to this concept.<sup>32</sup> Following constriction of the renal artery and performing a contralateral nephrectomy, Wilson observed a prompt increase in the plasma volume and in the extracellular fluid. These findings are compatible with the observation that the contralateral nonischemic kidney is observed to have decreased juxtaglomerular cell granularity following renal artery constriction. Thus it would seem that an increased renal plasma volume is associated with a decreased renin secretion.

#### The Juxtaglomerular Cell Response

On the basis of these observations, Tobian has proposed that the juxtaglomerular cell responds to alterations in renal arterial volume. By virtue of its position within the medial layer of the wall of the afferent arteriole, the juxtaglomerular cell is situated such that it might function as a "stretch receptor." In this concept, an increased renal arterial volume would lead to distention of the renal arterial bed and, in turn, distention of the juxtaglomerular cell. Conversely, any decrease in renal arterial volume would result in decreased distention of the renal arterial bed and decreased distention or decreased "stretch" of the juxtaglomerular cells. Therefore, factors such as sodium or renal artery constriction effect a decreased renal arterial volume which results in decreased juxtaglomerular cell distention. By functioning as a "stretch receptor" the degree of renin secretion would be inversely proportional to the degree of juxtaglomerular cell distention. Thus decreased juxtaglomerular cell distention leads to increased renin secretion and increased juxtaglomerular cell distention leads to decreased renin secretion.<sup>16,18,19</sup>

#### Conclusion

Recent studies indicate that the juxtaglomerular apparatus has an important role in the synthesis and release of renin. This role is effected by the juxtaglomerular cell, but the polkissen cell warrants inclusion as a component of the juxtaglomerular apparatus

by its ability to transform into a juxtaglomerular cell. The juxtaglomerular cell has been shown to be the site of renin synthesis and by functioning as a "stretch receptor," it may control renin synthesis and release by responding to alterations in renal arterial volume.

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**CENTRAL NERVOUS SYSTEM INVOLVEMENT BY VIRUSES.**—Two particularly interesting findings of a seven-year follow-up study of Western equine encephalitis and St. Louis encephalitis are reported: (1) Convulsions as a sequela of these two types of viral encephalitis have not occurred unless convulsions occurred during the acute illness. (2) Several children in the study, who had Western equine encephalitis in infancy and clinically recovered, developed intellectual and behavioral deficiencies several years later. This is interpreted not as evidence of progression of the primary disease process; rather it is due to damage to the maturation potentialities of the nonfunctioning portions of the brain at the time of the encephalitis in infancy. This interference with cerebral maturation may not become apparent until months or years later when the intellectual and behavioral functions normally become apparent.—K. H. Finley, M.D., San Francisco, Calif., *International Journal of Neurology*, 1/3:256-269 (June) 1960.



# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT G. THOMAS, M.D., *President*

## PRESENTATION OF CASE

**T**HIS white man, aged 49 years, entered Ohio State University Hospital with the chief complaint of pain in his left calf which occurred after he had walked a short distance. Over the past two to three years this pain had occurred after he had walked several blocks, and for the past three to six months the distance he could walk before the pain started had gradually become shorter. The pain was described as cramping in nature, occurred only during activity, and was relieved by rest. He had no such pain in his right leg. Two weeks prior to his admission he was started on nicotinic acid therapy by his family physician; this provided no noticeable relief in his symptoms. Ten years prior to this admission he had a small bowel resection because of mesenteric thrombosis; since then he had had no abdominal symptoms. He also had no paroxysmal nocturnal dyspnea, no episodes of acute chest pain, and no chest pain on exertion. He denied chronic cough or dyspnea on exertion. He had no genitourinary or gastrointestinal complaints. He had no history of diabetes.

## Physical Examination

The patient was an alert man who appeared somewhat older than his stated age. His blood pressure was 150/70 and his pulse rate was 80 per minute. There was a well-healed abdominal scar and no abdominal masses or tenderness. The heart rhythm was normal and there were no murmurs. The lungs were clear. The femoral pulses were felt bilaterally; however, on the left no pulse was palpable below the femoral pulse. There was a temperature differential with the left foot being somewhat colder than the right. Oscillometric examination showed no pulses in the left leg and normal pulses in the right leg.

## Laboratory Data

On admission, the urinalysis was normal; the hemoglobin was 14.5 Gm. with normal leukocyte and differential counts. A two-hour postprandial blood sugar was 102 mg./100 ml. The blood urea

## Presented by

- Richard Patton, M.D., Columbus, and
  - Jacob W. Old, M.D., Columbus.
- Edited by Emmerich von Haam, M.D.

nitrogen was 17 mg./100 ml. with a creatinine of 1.4 mg. An alkaline phosphatase was 4.7 units, an acid phosphatase 0.7 units. His prothrombin time was 81.5 per cent.

An electrocardiogram showed left axis deviation and a probable anterior septal infarction of indeterminate age. A repeat electrocardiogram was unchanged. The chest x-ray was reported as normal. A transfemoral aortogram showed essentially complete obstruction of the left common iliac artery with evidence of good outflow in the left leg. There was also evidence of aortic calcifications.

## Hospital Course

On the fourth hospital day an endarterectomy of both iliac arteries and the distal aorta was performed. The procedure was lengthy and was complicated by troublesome bleeding from a lumbar vein and some bleeding from the vena cava. During the surgical procedure the blood loss was estimated at 8000 cc., which was accurately replaced throughout the procedure. Prior to closing the abdomen gastrostomy was performed. The patient was noted to have several transient episodes of rather severe hypotension during the operation.

In the immediate postoperative period the patient was given dextran; he had had mannitol during the surgical procedure. His blood pressure in the recovery room ranged between 120/80 and 130/80, his pulse rate from 96 to 120 per minute. Postoperatively he ran a persistent tachycardia of 120 to 126. His urinary output was in the range of 15 to 40 cc. per hour during the first postoperative day. On that day his hemoglobin was 14 Gm. with a hematocrit of 42 per cent. His electrolytes were as follows:

CO<sub>2</sub> combining power 24, sodium 129, potassium 5.7, chlorides 108 mEq./L.

The blood urea nitrogen on the first postoperative day was 32 mg. Over the next eight hours his urinary output fell to almost zero, and on the second postoperative day he was seen in consultation by the Renal Dialysis service. At this time his blood urea nitrogen was 52 mg. He had become somewhat hypotensive, requiring additional transfusions and vasopressors to maintain an adequate blood pressure. He was also found to have abdominal distention and considerable abdominal pain. Bowel sounds were entirely absent at this time, and it was the impression that a major abdominal catastrophe had occurred. He remained anuric, his abdominal distention increased markedly, and his abdominal pain became more intense. On the second postoperative day he was found to have an amylase of 116 units, sodium of 121, potassium 6.4, chloride 89, and CO<sub>2</sub> 17 mEq./L. On the evening of the second postoperative day his hemoglobin was 7 Gm.

During the postoperative period he had antibiotics in the form of penicillin and streptomycin, he had intermittent positive pressure respiration treatments, and he had been given Neo-Synephrine® and multiple blood transfusions. Despite this he continued to be hypotensive with a tachycardia of 130. His urinary output on the third postoperative day was 2 cc. per hour, and his final blood urea nitrogen was 62 mg. He became unresponsive on the third postoperative day and despite some heroic efforts he died on that day. The patient was febrile throughout his postoperative course, and his white blood cell count was 19,700 on the second postoperative day.

#### CLINICAL DISCUSSION

DR. PATTON: I think first we should talk about the preoperative diagnosis of the patient; second, about his surgery, and finally about his postoperative complications. Actually, there is no question but that this patient had arteriosclerosis. He had evidence of it in many organs. He had a history of mesenteric thrombosis. Obviously the mesenteric thrombosis does not *have* to have been arterial, but it might have been. Furthermore, he had obvious aorto-iliac arterial occlusion on an arteriosclerotic basis. He also had good evidence on the electrocardiogram of a previous myocardial infarction, and he had some evidence of at least some type of vascular kidney disease with relative renal insufficiency. His preoperative creatinine of 1.4 is certainly a high normal and is some indication that his kidney function might not have been all it should have been.

#### Tobacco Hazard

I think one other interesting point in the preoperative diagnosis is that this man statistically has a 40 to 1 chance of having been a heavy cigarette smoker. Arteriosclerosis without diabetes in this

age group is observed, but you will find in a series of between 70 and 100 cases of severe peripheral arteriosclerosis only about two patients, or one out of 40, who are not heavy cigarette smokers, having smoked over a prolonged period of time more than a pack of cigarettes per day. There is nothing in the protocol about it, but if you assume that this man was a heavy cigarette smoker you would have at least a 40 to 1 chance of being correct.

Another interesting thing in the preoperative diagnosis is the statement that he had bilateral femoral pulses. Certainly from the looks of the angiogram that you see before you I would doubt if he had a left femoral pulse at all. Clinically and radiologically then he did have severe arterial occlusion of the left leg. Radiologically this can be located in the left common iliac artery, and I think this might be a good time to ask Dr. Dunbar to discuss the radiological findings.

#### Radiology

DR. DUNBAR: The chest film is normal. There is slight elongation of the aorta, certainly not abnormal for a man of his age. The arterial system visualized by percutaneous catheterization of the right femoral artery. This sometimes takes a little longer than the translumbar approach, but I think it is a little more comfortable for the patient, makes it a little easier to do repeat injections if necessary, and is the desirable technique if one can pass the catheter through these diseased arteries. The injection did put a small amount of dye into both kidneys. I doubt if the contrast had anything to do with his renal function after surgery but it could have contributed somewhat to his problems.

There is obviously a complete obstruction of the left common iliac to the point where there is collateral filling through both the lower lumbar and the hypogastric arteries, and some through the inferior mesenteric artery. There is severe disease of the lower abdominal aorta and moderate obstruction of the right common iliac. There is also some obstructive disease in the superior mesenteric artery with collateral flow coming from the inferior mesenteric artery.

DR. PATTON: So our x-rays show us that he did have partial occlusion of his right common iliac, total occlusion of his left common iliac, and there is a question as to an arteriosclerotic process with obstruction in the superior mesenteric artery. Actually, superior mesenteric artery obstruction itself is not an insurmountable problem for a patient, and the superior mesenteric artery can be totally obstructed if the inferior mesenteric and the celiac axis have relatively good blood flow. This can be an asymptomatic obstruction.

#### Choice of Procedures

I think it might be worth while to say a few words about the procedures which might be applied



in this situation. Actually you have a choice of two procedures. The first is the one attempted on this patient and that is thromboendarterectomy, where the obstructing thrombus and the arteriosclerotic plaque are removed. The second procedure, that is probably somewhat simpler although there is some evidence that it might not be quite as long lasting, is a bypass graft which would run from the anterior aorta to his good external iliac artery. This is technically an easier procedure since less dissection is necessary and there are fewer suture lines. If I had had this patient to deal with I would have attacked his problem by a bypass graft.

### Operative Complications

I think then that we should discuss his complications, both during surgery and during his brief postoperative phase. Two complications happened during his surgical procedure. He had a severe operative hemorrhage, and he had hypotension in spite of the replacement of blood. He had 16 units, or 8000 cc., of blood throughout the procedure, which is a large volume of transfused blood during any type of an operation and adds other problems to that of the blood loss. In arteriosclerosis of the aorta and of the iliac vessels there is actually an inflammatory mass which develops between these vessels and the vena cava and the lumbar veins, and in dissecting them off it is extremely easy to lacerate the vena cava, the lumbar veins, or the iliac veins.

Usually the best way to control the hemorrhage is to simply pack the area of bleeding and expose it by cutting your tissue plane so that you get to it. Once you have it exposed then it is no longer much of a problem, because hemorrhage from the vena cava, even though the vena cava is a quite large vein, is fairly easy to control. Oftentimes it is well to remember the pack technique because the veins bleed while you suture them and you tear further because you don't have a good exposure and you can end up very easily with an 8000 cc. blood loss as happened here. Of course with massive transfusions you must replace the calcium ions with each 4 units of blood. The other problem following massive transfusion is that of the dilution phenomenon. The patients have a low fibrinogen titer due to dilution of their blood with transfused blood and they do have difficulties with persistent bleeding after transfusion with this large amount of blood.

The second operative complication was his hypotension, and hypotension in a known arteriosclerotic man such as this is a serious complication. We know that this individual had a previous coronary. Secondary coronary occlusion after hypotension is not at all unusual. Other sclerosed vessels will slow the blood flow, and the renal vessels, the superior mesenteric, and the arteries of the opposite leg will often thrombose during a period of hypotension.

### Shock

Let's pass then from the operative to the postoperative complications, and I would like to discuss three of these. The first is the shock that occurred, the second is his renal insufficiency, and the third is his abdominal catastrophe. The shock that this patient had was due to one of two things — either continued hemorrhage or inadequate replacement. It occurred practically from the time he left the operating room, although he was stable for the first eight hours as measured by vital signs and a reasonable urinary output. The problem of continued hemorrhage or inadequate replacement in a complicated case such as this is a very severe problem, because it is hard to answer the question: When do you stop transfusing? There are really only four ways for finding this answer. First is the determination of the weight of the lost blood; second, his vital signs are followed; third, his urinary output is measured; and fourth, his central venous pressure is monitored. The latter is probably the best way for an adequate estimation of the replacement. When the pressure comes back up towards normal limits the transfusion should be stopped.

### Renal Insufficiency

The second complication was his renal insufficiency. There is very little question but that it was a prerenal type of renal insufficiency. Renal tubular necrosis was probably present at the time of death but it certainly did not have anything to do with his death. If he had lived long enough he would certainly have been a likely candidate for renal failure. He probably had some degree of renal arteriosclerosis with preëxisting renal damage; he had an operation involving the retroperitoneal space and these are known to cause renal problems postoperatively; he had a period of hypotension during his operation and anesthesia, and finally he had massive blood loss and a sodium deficit as measured by his electrolytes on his first and second postoperative days.

### Sodium Deficit

Probably the simplest way to measure a sodium deficit is to subtract his serum sodium as measured in milliequivalents from the normal and multiply this by his approximate extracellular fluid space, which in a 70 Kg. man is 14 liters. In this patient we would arrive at a deficit of sodium of 224 mEq. on his first operative day and an additional 126 mEq. deficit between the first and second days. I would judge that his increase in potassium, his decreased chloride and his acidosis were all parts of this primary sodium deficit.

The first step that was taken in this patient was the use of mannitol during the course of his operative procedure. I don't know how much mannitol he had, but I would favor somewhere between 25

and 50 Gm. in a 5 to 10 per cent solution during the course of his surgical procedure.

I consider his abdominal catastrophe on the second postoperative day the real cause of his death. Two things could have caused this abdominal catastrophe. He could have had a massive retroperitoneal hemorrhage. It is obvious that he had continued concealed blood loss during his first 48 hours postoperatively because his hemoglobin dropped from 14 to 7 Gm. This could have gone into his retroperitoneal space and produced all the pathophysiologic changes in this patient. However, purely from the amount of pain that this man had, and considerable mention of this is made in the protocol, I think we would have to consider a mesenteric thrombosis. I think the indications toward mesenteric thrombosis first appeared in the angiogram, where we really did not see a good superior mesenteric artery. If this mesenteric artery was not occluded but only narrowed, then a complete occlusion could have occurred during his first 24 hours postoperatively. The same symptoms would occur except that the pain would be greater in mesenteric thrombosis, and I would be inclined to think that this was his terminal problem—that he had mesenteric thrombosis due to superior mesenteric artery occlusion and that actually this was the cause of death.

#### General Clinical Discussion

DR. TAFT: Do you want to be a little more definite about what you think was the cause of this man's death?

DR. PATTON: I thought that the hemorrhage and hypotension were sufficient to cause thrombosis in an already damaged superior mesenteric artery and that this superior mesenteric artery thrombosis was the primary cause of death.

COMMENT: Dr. Patton, sometimes it is rather difficult to tell whether you have a patient overhydrated or whether you are behind with fluid. I would think that this man really had dilutional hyponatremia.

DR. PATTON: I suppose that we would have to rely on our monitored venous pressure and daily or every 12 hour serum sodium determinations as the only way to find this out.

COMMENT: You can use your venous pressure unless he had a myocardial infarction during his hypotensive episode; then you can't use that.

DR. PATTON: Then your venous pressure is inadequate. But there isn't anything else that is adequate in this situation.

DR. VON HAAM: Did he have a septicemia with his blood count and his fever? How would you explain that?

DR. PATTON: I would judge that his blood count could be explained on the basis of his mesenteric thrombosis. I would think that this was a

little early for death from septicemia and would be more inclined to place it as a vascular complication.

#### CLINICAL DIAGNOSIS

1. Severe generalized arteriosclerosis with:
  - a Complete occlusion of the left common iliac artery.
  - b Partial occlusion of the right common iliac artery.
  - c Coronary artery sclerosis.
  - d Partial occlusion of the superior mesenteric artery.
2. Shock with hypotension due to blood loss.
3. Superior mesenteric artery thrombosis.

#### PATHOLOGIC DIAGNOSIS

1. Severe generalized arteriosclerosis:
  - a Status post-endarterectomy.
  - b Coronary artery sclerosis.
  - c Thrombosis of superior mesenteric artery.
2. Early necrotizing enteritis.
3. Massive infarct of liver.

#### DISCUSSION OF PATHOLOGY

DR. OLD: The body was that of a man who looked older than his reported age. His heart showed an old infarction which had fibrosed over a long period of time. The left coronary artery was pretty firmly sclerosed and partially occluded. The lungs were moderately congested but appeared dry. The liver showed a rather sharply demarcated large area of yellowish discoloration, usually indicating necrosis. The small intestines were dark red and distended; the mucosa revealed hemorrhages and a dusky discoloration. The process extended to the colon, which appeared normal in color. The superior mesenteric artery was completely occluded by an organized thrombus. No massive hemorrhage was found. The aorta below the level of the renal arteries and both iliac arteries had been incised and were closed with tight silk sutures. The endarterectomy had removed the intima and left a very smooth media with no evidence of recent thrombosis. Both renal arteries were patent and not significantly compromised by the sclerotic process. The iliac arteries as well as the inferior mesenteric artery were patent.

*Microscopic examination* confirmed the gross diagnosis of an old myocardial infarct. The liver cells in the discolored area were severely damaged, showing all grades of cytoplasmic degeneration to liver cell necrosis. Section of the small bowel showed complete necrosis of the epithelial lining of the mucosa with moderate congestion of the visceral wall. Sections through the kidneys showed no significant arterial nephrosclerosis and most of the kidney parenchyma appeared in good shape.

It is my opinion then that the patient did indeed suffer from severe generalized arteriosclerosis which had affected mostly the larger arteries. He did have



an old superior mesenteric artery occlusion which was asymptomatic until the patient went into shock and hypotension. At this stage the collateral circulation did not suffice and the patient suffered from infarction of the liver and ischemic necrosis of the small bowel. Both of these lesions then aggravated his shock and were the cause of his death. I am certain that his blood volume problem and his electrolyte imbalance which Dr. Patton has mentioned contributed to his death. However, I feel that the necrotic changes present in two major organic systems—the liver and the small bowel—were the most important fatal lesions.

### General Discussion

DR. VON HAAM: That would explain the high fever in this patient?

DR. OLD: The blood cultures were negative and there was nothing to indicate any type of inflammatory process anatomically in this patient.

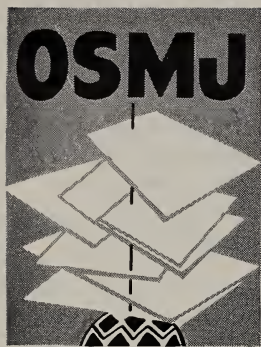
QUESTION: How do you explain the drop of his hemoglobin from 14 to 7 Gm.?

DR. OLD: There was blood loss into the tissues in the sense of loculation of considerable quantities of blood in the capillaries of the bowels.

**SEPTIC SHOCK IN PREGNANCY.**—A review of the charts of all patients (18) with the diagnosis of septic, bacterial, or endotoxin shock during the year 1962 led the author to conclude that, although antibiotic therapy is by far the most important part of the over-all treatment of the septic pregnant patient, massive amounts of endotoxin or bacterial dead products will be released into the blood stream if large parenteral dosages of the appropriate antibiotic are given when the bacteria are in the early phase of growth. This appears to intensify and hasten vascular collapse, which will respond readily to steroids when given before the shock becomes irreversible. In the four representative cases reported in detail, blood pressure was stabilized by the following treatment: (1) 200 mg. intravenous Solu-Cortef® (hydrocortisone sodium succinate) and 30 mg. of Wyamine® (mephentermine sulfate), (2) steroids alone, (3) 200 mg. of Solu-Cortef and use of the Trendelenburg position, and (4) Solu-Cortef and minimal vasopressors.

The retrospective study was made in 18 patients 16 to 35 years of age with (1) clinical or laboratory evidence of bacterial infection and (2) vascular collapse without significant blood loss. Sixteen patients received large parenteral doses of antibiotics; the infection appeared to be under control after 12 to 24 hours, and moderate doses were given for 5 to 7 days. Shock appeared at 8 to 24 hours and often occurred when the patient showed few signs of general toxicity. Two patients did not respond clinically to massive intravenous doses of antibiotics for three days; when they received the appropriate drug as indicated by sensitivity studies, the typical hypotensive episode occurred within 12 to 24 hours, suggesting that release of endotoxin or bacterial dead products may have triggered the onset of vascular collapse. Half of the patients with septic abortion were subjected to curettage after 12 hours of therapy with antibiotics, oxytocics, and blood replacement; episodes of hypotension occurred in each instance. All 18 patients had a dramatic drop of systolic blood pressure; the drop was 40 to 70 mm. Hg in over half of them. The pulse rate was slow or normal in nine patients and was rapid in eight; one had no pulse. All patients had elevated temperature prior to the onset of shock, but hypothermia or minimal fever while in shock.

It is recommended that, in general, septic abortion be treated with curettage preceded by 12 hours of antibiotic therapy; hysterectomy is sometimes required. Antibiotics chosen by use of the gram stain should be given until the results of culture and sensitivity studies are available. Weil recommends dosage as high as that used in subacute bacterial endocarditis. Over half the organisms in the present series were gram-negative, but *Staph. aureus* and anaerobic streptococci were also cultured. Evidence is accumulating that pharmacologic doses of corticosteroids are effective in septic shock. — (ABSTRACT), Blanche D. Coleman, M. D., Augusta, Ga.: *Obstetrics and Gynecology*, 24:895-902 (December) 1964.



# NEWS AND *Organization Section*

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## Proceedings of The Council...

Report of Matters Considered and Actions Taken  
At Meeting Held in Columbus on March 27 and 28

A REGULAR meeting of The Council of the Ohio State Medical Association was held on March 27 and 28, 1965, at the OSMA Headquarters Office, Columbus. All members of The Council were present except Dr. Horatio T. Pease, Wadsworth, Past-President. Others attending the meeting were: Dr. John H. Budd, Cleveland, Chairman of Ohio's AMA delegation; Mr. Wayne Stichter, Toledo, legal counsel; Mr. George H. Saville, OSMA consultant; and Messrs. Page, Edgar, Gillen, Trap-hagan and Moore, members of the OSMA staff.

### President's Remarks

President Tschantz thanked members of The Council for their devotion to duty during a busy year which has required additional meetings and extra work.

He asked the Councilors to promote the 1965 Annual Meeting through the committeemen in each district appointed for this purpose and to encourage members to bring interns and residents to the meeting.

Dr. Tschantz urged that lines of communications among physicians be kept open so that all may be aware of state and national developments.

### Minutes Approved

Minutes of the special meeting of The Council held on January 31, 1965, were approved by official action.

### Membership Statistics

The following membership statistics were reported by Mr. Page: OSMA membership as of March 23, 1965, 8,605, compared to a total membership of 8,548 on March 23, 1964 and 9,933 on December

31, 1964. He reported that of the 8,605 OSMA members, 7,509 were affiliated with the AMA.

### Reports from Councilors

Reports on the activities in their districts were given by the Councilors.

### OMI Board of Directors

Dr. Fulton, as chairman, presented a report of the nominating committee appointed by the President to submit the names of candidates for the Board of Directors of Ohio Medical Indemnity, Inc. The committee recommended that the following be nominated and elected for the ensuing year: Ralph L. Abernathy, Dayton; Dwight L. Becker, M.D., Lima; H. M. Clodfelter, M.D., Columbus; Clair E. Fultz, Columbus; Carl W. Koehler, M.D., Cincinnati; Edgar O. Mansfield, Columbus; Robert S. Martin, M.D., Zanesville; J. A. Meckstroth, Columbus; George L. Sackett, M.D., Painesville; John Schoedinger, Columbus; Frank L. Shively, Jr., M.D., Dayton; Harold W. Slabaugh, Akron; Msgr. John C. Staunton, Cincinnati; Gordon M. Todd, M.D., Toledo; Edmond K. Yantes, M.D., Wilmington; Starling C. Yinger, M.D., Springfield; J. Martin Byers, M.D., Greenfield; Sander Goodman, M.D., Cincinnati; George J. Hamwi, M.D., Columbus; William A. White, Jr., M.D., Canton; Francis M. Wistert, Toledo.

By official action The Council approved the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting of OMI in April on all business matters coming be-



fore that meeting, including the election of directors placed in nomination by The Council at this meeting on March 27-28, 1965: Dr. H. M. Clodfelter, Columbus, or Dr. Edmund K. Yantes, Wilmington, or Mr. Hart F. Page, Columbus.

### Report of OMI Liaison Committee

A report of the Ohio Medical Indemnity Liaison Committee was submitted in writing by Dr. Pease. The report was approved as submitted and it read as follows:

"This is not a report of the Liaison Committee as a whole — since the Committee has never met separately but during the last two years members of the Committee have met with and participated in the discussion at each meeting of the Board of Directors and each meeting of the Executive Committee.

"OMI started in 1945 with the Standard Contract and since then many other policies have been put in force. Throughout the years there was a healthy growth, building up a good reserve, frequently increasing benefits to policyholders. All this was done without any increase in premiums.

"However, in 1962, income and expenses about broke even and in 1963 OMI operated \$629,000.00 in the red. In 1964 it became necessary for the first time to make a small increase in premium. At the end of 1964, 90 per cent of policies were paying the increase, and OMI showed a net profit for the year of \$234,000.00. At the end of February 1965, \$679,000.00 was transferred to General Reserve. There was no complaint from policyholders due to the increased premium. The reserve now is equivalent to 6.47 months' operation.

"Each month shows a decrease in the number of Standard Contracts with an increase in Preferred Contracts — a constant up-grading with a steady gain in subscribers — 11,000 in 1964 — bringing the total number of subscribers to 2,352,336.

"The new Comprehensive Policy is now approved in 66 counties. Most of the 22 counties which have not approved the plan are small rural counties, though there are a few populous counties such as Summit and Stark Counties that have not approved the plan. To date, 4,544 contracts are in force, mostly in the Cincinnati, Toledo, Columbus areas. The experience with this plan has been highly satisfying. There has been essentially no complaint and no need to use grievance committees. The plan is attracting national interest.

"Physician relations has been good and has doubtless been improved due to the monthly 'Newsletter' sent to all physicians by OMI.

"OMI is a going concern, never static, always increasing benefits. Recently physician compensation for 'Direct current cardioversion' and for use of the 'Artificial Kidney' was approved.

"At the present time consideration is being given to the Lasar light, coagulation treatment of retinal detachment, gastric freezing, use of isotopes and implantation of cardiac pacemakers.

"Also under research is — (1) a new student policy for college students; (2) an antiduplication clause, and (3) negotiations with the Federal Government to put all Federal employees in Ohio under the Comprehensive Plan.

"My experience on this liaison committee has been wholesome, very pleasant and educational and I believe the committee members have materially contributed to the success of OMI.

"I feel that nearly all members of the Board of Directors and members of committees are dedicated men who give much time and effort to serious planning in promoting OMI for the good of our patients in Ohio."

### Rotation of Members on OMI Board

On motion duly made, seconded and carried, the President was instructed to appoint an ad hoc committee to study the feasibility of establishing a plan of rotation of members on the Ohio Medical Indemnity Board of Directors, the committee to report at the Fall meeting of The Council. The President appointed the following to this committee: Dr. Richard L. Fulton, Columbus, chairman; Dr. Robert N. Smith, Toledo; and Dr. Robert E. Howard, Cincinnati.

### Anesthesiology Benefits

The Council voted to approve a motion that Ohio Medical Indemnity be urged to use the same method and techniques in the payment to subscribers using the services of anesthesiologists as are now used for the payment of benefits to subscribers using other physicians.

### Suggestions for Insurance Committee

The President again asked The Council to submit suggestions for members to serve on the OSMA Insurance Committee, authorized by The Council at its meeting on September 19-20, 1964.

A communication from the Continental Assurance Company, Chicago, Illinois, regarding the Illinois State Medical Society Retirement Investment Program and its companion Tax-Qualified Retirement Program was referred to the OSMA Insurance Committee.

### OSMA Group Life Plan

A report from Turner and Shepard, Inc., on the Ohio State Medical Association group life insurance plan, covering the period from March 1 to September 1, 1964, was approved.

### Major Medical Insurance Program

A report from Daniels-Head & Associates, Inc., Portsmouth, on the OSMA major medical insurance

program during the first year of operation ending December, 1964, was approved. (See page 479.)

### Report on County Society Officers Conference

Mr. Edgar reported on the County Society Officers Conference held at the Columbus Plaza Hotel on February 28, 1965. It was suggested by members of The Council that the program for next year's conference be scheduled to end one hour earlier in the afternoon.

### 1965 Annual Meeting

The minutes of a meeting of the Committee on Promotion of Attendance at the 1965 Annual Meeting were approved.

Hosts were assigned for distinguished guests who will attend the Annual Meeting the week of May 9.

Resolutions filed in advance of the meeting were submitted to The Council by the Executive Secretary.

### Butler County Amendment

An amendment to the Bylaws of the Butler County Medical Society regarding a change in dues was approved as submitted, with a minor correction in the title concerning the fact that the amendment is to the bylaws rather than to the constitution.

### Clermont County Amendment

An amendment to the Constitution of the Clermont County Medical Society regarding changes in requirements for a quorum at meetings was approved as submitted.

### Licking County Amendments

Amendments to the Constitution and Bylaws of the Licking County Medical Society, concerning the separation of the office of secretary-treasurer into two offices and a change of the regular meeting date of the society, received final approval by The Council.

### Mahoning County Amendments

Amendments to the Constitution and Bylaws of of the Mahoning County Medical Society, involving procedures for the election of officers, were approved, subject to redrafting in order to eliminate a contradiction and to repeal one section.

### Committee Reports

**Maternal Health**—The report of the Committee on Maternal Health, based on a meeting held on January 23-24, 1965, was approved.

On motion duly made, seconded and carried, The Council instructed the committee to invite Dr. Emmett W. Arnold, Ohio Director of Health, and Dr. Anthony Ruppertsberg, chairman of the committee, to meet with The Council in regard to the implementation of the program developed in connection with the problem of integration of certain gynecological patients with obstetrical patients on maternity floors in Ohio hospitals.

The Council authorized the President to refer a protocol presented by Dr. Gilbert M. Schiff, Assist-

ant Professor of Medicine and Microbiology, University of Cincinnati, on the subject of rubella in mothers and the newborn to the Committee on Maternal Health for study.

**Athletic Injuries**—Reports of the Joint Advisory Committee on Athletic Injuries of the Ohio State Medical Association and the Ohio High School Athletic Association, based on meetings held on February 17 and March 17, were approved.

**Rural Health**—The report of the Committee on Rural Health, based on a meeting held on February 6, 1965, was approved.

**Hospital Relations**—The report of the March 21 meeting of the Committee on Hospital Relations was presented by Mr. Gillen.

The Council considered a "Guide for the Release of Information from Medical Records," submitted by the committee for consideration. The Council requested the deletion of paragraphs A-1 (a) of Chapter II and A-1 (c) of Chapter II on page 2 of the Guide. The OSMA legal counsel was asked to present to The Council an interpretation of paragraph D on page 4. Approval of the Guide was withheld pending the implementation of these suggestions.

The Council approved the minutes of a joint meeting of the OSMA Committee on Hospital Relations and the Professional Relations Committee of the Ohio Hospital Association held on March 21, 1965. These minutes included a proposal regarding an institute on areawide planning for health facilities scheduled for the Fall of 1965; and a recommendation that a meeting be arranged with representatives of Blue Cross, Blue Shield, the Ohio Hospital Association and the Ohio State Medical Association with regard to the removal of the interpretation of electrocardiograms and other such physician services from the category of hospital services.

**Cancer**—The report of the Ohio Cancer Coordinating Committee, based on a meeting held on March 11, 1965, was presented by Mr. Traphagan.

A section on page 4 of the minutes, calling for application to the United States Public Health Service for funds to be used to employ an expert in cancer registry formation and operation for the purpose of encouraging additional registries in Ohio, was disapproved. The remainder of the minutes received the approval of The Council.

**Workmen's Compensation**—The report of the Committee on Workmen's Compensation, based on a meeting held on January 27, 1965, was approved.

**Future Planning**—The report of the Committee on Future Planning, based on a meeting held on February 28, 1965, was accepted and approved as a progress report.

An invoice from the J. Edwin Farmer Company "for drawings, specifications and cost estimates on proposed trade association building as authorized by



your Building Committee" was considered by The Council. The Association legal counsel was instructed to write a letter to this firm, advising it as to the extent of the OSMA obligation as outlined in an agreement dated August 12, 1964.

**Ohio Medical Political Action** — A report from the Ohio Medical Political Action Committee, based on a meeting held on February 27, 1965, was accepted as information.

### Federal Legislation

Mr. Edgar reported on the latest developments in Federal legislation, including the drafting of H. R. 6675 and its submission to Congress by the House Ways and Means Committee.

After considerable discussion The Council, on **motion** duly made, seconded and **carried**, authorized the president to appoint a committee, including the president, past-president, president-elect, chairman of the Auditing and Appropriations Committee and the treasurer, to act for The Council in the expenditure of reserve funds of the Association necessary to carry on the educational campaign on national issues facing the medical profession. It was the expression of The Council that the fight for the freedom of medicine is not lost. The campaign to inform the public and the Congress of the necessity to preserve the American system of health care must continue in full force. The Ohio State Medical Association will support and supplement activities of the American Medical Association in this vital mission.

Mr. Edgar then presented information concerning S. 512 and H. R. 2984, the health research facilities amendments pending in the Congress. On **motion** duly made, seconded and **carried**, The Council adopted the following statement as Ohio State Medical Association policy on these measures:

"The Ohio State Medical Association opposes the methods proposed in S. 512 and H. R. 2984, the health research facilities amendments, although the objective of improving care for vascular diseases and cancer is salutary. The centers suggested (1) constitute duplication of existing facilities; (2) would create the false impression that some 'magic advance' could be achieved in such centers which could not be similarly achieved in existing facilities; and (3) the provisions would bring about a lessening of the effectiveness of existing institutions which already provide this health care.

"The existence of such proposed facilities, necessarily in proximity to already functioning institutions, in which all developments in cancer therapy and therapy for heart disease and strokes are already implemented as soon as discovered, would impugn the effectiveness of such functioning institutions.

"Since the proposal would necessitate a massive expenditure for duplication of facilities and per-

sonnel, the need for which has not been demonstrated, and the implementations of which would react adversely to many of the existing health care programs involving the diseases mentioned, we believe that the legislation is not in the best interests of the public.

"The construction and staffing of the number of diagnostic and treatment centers contemplated in this proposal would result in a serious disruption of the medical staffs of existing medical facilities providing the same services, and would work an unnecessary and considerable hardship on the positive programs being carried out today, as evidenced by medicine's rapid advances in the fields of investigation and treatment involved.

"It has not been demonstrated and, in the opinion of this Association, cannot be demonstrated that any person who requires the services such centers might provide cannot find these services within reasonable distance of travel.

"Finally, this proposed legislation would place the Federal government directly into a medical program of a true socialized nature ('Socialism: a theory or system \* \* \* by which the means of production and distribution are owned, managed, or controlled by the government.' — *World Book Encyclopedia Dictionary* — 1963 edition.)"

The Council also voted to oppose the use of Federal funds for the staffing of mental health centers.

### State Legislation

The Council considered communications with regard to the Ohioans for Jobs and Progress Committee and the promotion of four state constitutional issues to be submitted at the Ohio primary election on May 4, 1965. On **motion** duly made, seconded and **carried**, The Council voted OSMA support of Constitutional Issues 1, 2, 3 and 4, and instructed the president to accept a position as trustee on the Ohioans for Jobs and Progress Committee.

In answer to a letter from Dr. James C. McLarnan, Mt. Vernon, president of the Ohio Coroners' Association, The Council voted to support more active participation by physicians with regard to the office of coroner and to support efforts for better remuneration for coroners.

The Council discussed a number of matters before the 106th Ohio General Assembly and established policies with regard to certain issues and legislative measures. (See pages 467-469 of this issue for action taken on the various bills.)

### St. Anthony Emergency Room Physicians Service, Inc.

The Council discussed the St. Anthony Emergency Room Physicians Service, Inc., at the request of the Columbus Academy of Medicine. The following statement was adopted by The Council: "The Coun-

cil sees nothing illegal or unethical about the plan submitted."

#### **Zip Code Postal Regulation**

Mr. Moore discussed Association mailing problems created by the recent regulations issued by the United States Post Office Department. Such regulations involve the use of Zip Codes on all addressograph plates and the rearranging of second and third class mail by Zip Code area rather than by counties. Mr. Moore estimated that new addressograph plates would be necessary and that the cost of this procedure alone would be more than \$1,000.00.

#### **Blood Insurance Programs**

The Council voted continued opposition to the licensing of blood insurance programs and authorized representatives of the Ohio State Medical Association to participate in a hearing proposed by the Ohio Department of Insurance on such programs.

#### **Dispensing of Drugs by Nurses**

A letter from the Ohio State Nurses Association regarding the dispensing of drugs by nurses was referred to the Committee on Hospital Relations for study.

#### **Woman's Auxiliary**

The President read a communication from Mrs. John Dickie, President of the Woman's Auxiliary to the Ohio State Medical Association, acknowledging receipt of funds appropriated by The Council to assist in the operation of the Auxiliary.

#### **June AMA Meeting**

Dr. Budd reported on plans for the Ohio delegation's participation in the American Medical Association meeting in New York City, June 20-24. The Council approved his verbal report and the minutes of the meeting of the delegation held on February 27, 1965, which included plans for the campaign to elect Dr. Charles L. Hudson as president-elect of the American Medical Association.

#### **Metropolitan Life Insurance Company**

The Executive Secretary presented for the information of The Council a letter from the Metropolitan Life Insurance Company with regard to a meeting of representatives of that firm with the Licking County Medical Society.

#### **First Aid Plan for Legislators**

A verbal request to the Executive Secretary by Lt. Gov. John Brown, with regard to the development of a first aid plan for members of the legislature while in session in Columbus, was presented. The Executive Secretary was authorized to explore with the Columbus Academy of Medicine methods of implementing such a program.

#### **Change in OSMA Statutory Agent**

On motion duly made, seconded and carried, The Council adopted the following resolution regarding

a change in statutory agent for the Ohio State Medical Association:

"BE IT RESOLVED, That Hart F. Page is hereby appointed by the Ohio State Medical Association as its agent on whom process, tax notices and demands against said Ohio State Medical Association may be served, to succeed George H. Saville, said appointment to become effective April 1, 1965."

#### **Measles Vaccine Education Campaign**

A proposal for a measles vaccine education campaign was referred by The Council to the Committee on School Health for study.

#### **Medical Assistants**

An information report with regard to the Ohio Society of Medical Assistants was presented by Dr. Meredith.

#### **Eye Examinations**

A letter from the Ohio Ophthalmological Society with regard to a communication from Captain W. E. Timberlake of the State Highway Patrol, concerning the uniform eye examination used in the driver license examining program, was received.

#### **Request for Funds**

A request for funds for the Junior Engineers and Scientists Institute was considered. It was the opinion of The Council that such funds could not be contributed at this time, since the item was not a part of the contribution budget established in December.

#### **Ohio Diet Manual**

Revisions in the Ohio Diet Manual were approved.

#### **President Commended**

On motion by Dr. Hardyman and seconded by many, The Council unanimously voted its thanks to Dr. Robert E. Tschantz for his devoted and inspirational leadership of The Council and the Association during his term of office.

#### **Executive Session**

The Council then went into executive session. The following report of the Auditing and Appropriations Committee was approved:

"The Auditing and Appropriations Committee met following the evening portion of the March 27 meeting of The Council. Present were: Drs. Tschantz, Crawford, Hardyman, Beardsley, Howard, Meredith and Mr. Page.

"The committee recommends, in recognition of increasing responsibility and service with *The Journal* since 1948, that Mr. R. Gordon Moore be designated Executive Editor and Executive Business Manager of *The Ohio State Medical Journal*." The meeting then adjourned.

Attest: HART F. PAGE,  
Executive Secretary



# Policy Action Taken by The Council On Bills in Ohio Legislature

THE Council of the Ohio State Medical Association, at its meeting on March 27 and 28, 1965 studied and discussed many legislative proposals affecting medicine and public health, pending in the 106th Ohio General Assembly. Bills subsequently introduced will be considered at a future meeting of The Council.

Following is an excerpt from the minutes of The Council, listing the legislative measures considered and the policy established by Council action:

**H. B. 5** — To eliminate "other assets" from consideration in determining support of patients in benevolent institutions. **Approve in Principle.**

**H. B. 6** — To establish a Children's Psychiatric Hospital within the city of "Toledo." (Council action January 31, 1965: no position on this bill). **Reaffirm.**

**H. B. 30** — To increase the statutes of limitations for malpractice suits, slander, etc. (OSMA actively opposed this bill. It was indefinitely postponed February 4, 1965 by House Judiciary Committee). **Opposed.**

**H. B. 33** — To permit counties to participate in programs under the "Economic Opportunity Act of 1964." **No position.**

**H. B. 45 and H. B. 147** — To require an identification emblem for certain types of slow moving vehicles. (OSMA Council voted on December 13, 1964 to support this type of legislation). **Continue support.**

**H. B. 62** — To permit electors admitted to a hospital under emergency conditions immediately prior to an election to obtain absent voters' ballots. **No objection.**

**H. B. 73** — Relative to voting by permanently disabled voters; requires Doctor's certificate. **No objection.**

**H. B. 84** — To permit payment of the state subsidy for specifically training of mentally deficient persons regardless of age of such persons. **Approved.**

**H. B. 92 and H. B. 142** — To establish an air pollution control board. **Active support.**

**H. B. 99** — To require seat belt assemblies in all cars sold in Ohio that are manufactured after January 1, 1966. (OSMA Council approved support of this type legislation September 19-20). **Continue support.** (Also approved requirement for rear seat belts).

**H. B. 108** — To permit the admission of testimony by means of deposition of physicians who reside within the county in which the suit is being tried. (Passed House week of February 25, 72-56). **Active support.**

**H. B. 120** — To permit the sale of drugs and articles to prevent conception. **Support.**

**H. B. 121** — Relative to the operation of motor vehicles while under the influence of alcohol: "Implied consent" bill. (OSMA Council on July 25, 1964 **approved support of this type of legislation in principle.** Bill killed in House Judiciary Committee March 17, 1965.)

**H. B. 124** — To require the Ohio Director of Health to designate each year, the county, district or municipal tuberculosis hospitals "needed to provide sufficient beds. . ." **No action.**

**H. B. 133** — To prohibit the advertising of dangerous drugs to the public. (OSMA House of Delegates determined at its 1964 session that OSMA should **actively support** this type of legislation. This bill was recommended for passage by the House Health Committee on March 9 by a vote of 9-4).

**H. B. 173** — This bill would increase the minimum population to constitute a city health district from the present 5,000 to 25,000. Smaller cities having health districts could keep them until January 1, 1968. **Reaffirm support.**

**Am. H. B. 218** — To require municipal or county peace officers receiving from a physician a report of possible child abuse to refer such report to the county welfare department or child welfare board for investigation, was heard before the House. Amended House Bill was passed. **Approve in principle.**

**H. B. 222** — To change the time a person must be a patient in an institution controlled by the department of mental hygiene, before his relatives are relieved from support charges. **No position.**

**H. B. 247** — To enable recipients of public assistance to retain earnings within minimum assistance standards. **No objection.**

**H. B. 257** — Define "coroner" and require funeral directors to report suspicious deaths to the coroner immediately. Also changes wording from "hold an inquest" to "make inquiry." **No objection.**

**H. B. 305** — To increase salaries of employees of state hospitals for the criminally insane, employees in

receiving areas and all employees in maximum security wards of mental hospitals except superintendents, staff physicians and attendants. **No position.**

**H. B. 342** — Would provide a new code section as follows: "Sec. 749.36 Every hospital shall keep complete medical records of its patients. Said records shall not be altered by erasure or any other means which would obscure the reading of any altered part. Records and X-ray negatives shall be for the benefit of the hospital treating personnel, and patients. Such records shall be made available at all reasonable times to patients, attorneys representing patients, or any other person authorized by a patient, or his parent or guardian if such person is legally incompetent." A penalty clause providing a fine of not more than \$500 for violation of the provision accompanied the new section. **Vigorously oppose.**

**H. B. 373** — OSMA bill to make it unnecessary for voluntary cancer registries to report to the Central Registry operated by the Ohio Department of Health. **Bill was approved for OSMA sponsorship January 31, 1965.**

**H. B. 376** — To revise the administration and financing of welfare programs, has been introduced and referred to the House Committee on Public Welfare. The measure would consolidate all public assistance programs under the county welfare department and provide a uniform formula for financing them. County welfare departments would be responsible for administering aid for the aged as well as other assistance programs. The lien provisions of the present aid for aged programs would be extended to aid for disabled and aid for the blind. **Approve.**

**H. B. 381** — To require blood type to be recorded on driver licenses. **Oppose.**

**H. B. 413** — Require motor vehicles, after January 1, 1967 to be equipped with air pollution control devices. **Approve.**

**H. B. 417** — Hill-Burton amendments (puts community mental health centers under the control of the Ohio Department of Mental Hygiene and allows Ohio to receive Federal operating funds). **Oppose as written.**

**H. B. 439** — To amend section to provide for the tolling of the statute of limitations for disabilities arising after the accrual of the cause of action. **Oppose.**

**H. B. 457** — Permits vacancy in office of director of local mental health clinics to be filled on a consultant basis. **Approve in principle.**

**H. B. 465** — To give one per cent of liquor permit fees to State Health Department for alcoholism program. **No action.**

**H. B. 473** — Establishes test for criminal insanity. **Oppose.**

**H. B. 478** — To impose tax on soft drink sales;

1¢ on 16 ozs. or less; 2¢ on more than 16 ozs.; for benefit of State Board of Education and Department of Mental Hygiene. **No action.**

**H. B. 564** — Establishing a central organizational unit to carry out the administrative functions of the accountancy board, state board of examiners of architects, board of barber examiners, state board of cosmetology, state dental board, board of embalmers and funeral directors, state nurses' board, state board of optometry, state board of pharmacy, state medical board, and the state board of registration for professional engineers and surveyors. **Approve in principle.**

**H. B. 567** — To provide for a separate division of mental retardation within the department of mental hygiene and correction. **Oppose.**

**H. B. 569** — To prohibit driving while under the influence of barbiturates. **Oppose.**

**H. J. R. 37** — Requests American Medical Association to make physician ownership or participation in ownership of a pharmacy unethical. **Oppose.**

**Senate Res. 36** — Memorializes Congress to adopt the King-Anderson Bill. **Oppose.**

**S. B. 5** — Relative to day care centers for children. **No position.**

**S. B. 7** — To require the installation of seat safety belt assemblies in all cars registered in Ohio which are manufactured after January 1, 1966. (OSMA Council approved support of this type legislation at their September 19-20 meeting). **Continue support.** (Also approved requirement for rear seat belts).

**S. B. 14** — To amend the Professional Corporations Act. **Needs further study.**

**S. B. 19** — To require phenylketonuria tests for all newborn infants. **Approve on voluntary basis.**

**S. B. 35** — To create a state board of nursing home and rest home examiners and to establish regulations. **Oppose.**

**S. B. 57** — To authorize purchase of the Brecksville Hospital located in Cuyahoga County for use as a hospital for mentally retarded children. **Oppose.**

**S. B. 108** — Relative to the creation of an advisory board to the state board of cosmetology, membership of the state board of cosmetology, and the licensing of cosmetologists, managing cosmetologists, instructors, and manicurists. **Oppose elimination of physician from board.**

**S. B. 124** — To have the Board of Building Standards adopt standards, rules and regulations to facilitate the free and unobstructed access and use of all public buildings and facilities by handicapped persons. (Cleveland Academy of Medicine has submitted resolution to OSMA House of Delegates relative to this subject). **Approve in principle.**

**S. B. 142** — To reduce Ohio personal property taxes, has been introduced and referred to the Senate



Taxation Committee for hearing. Under terms of the bill, property now assessed at 70 per cent would be reduced three per cent per year for ten years, ultimately reaching 40 per cent. This approaches the percentage at which real property is generally assessed. **Support.**

**S. B. 145** — To create an Ohio Medical Advisory Commission, consisting of the Director of Health and five members appointed by the Governor, has been introduced and referred to the Senate Committee on State Government. **Oppose as unnecessary.**

**S. B. 153** — To include blood type, any requirement for insulin, and a photograph, on all driver licenses, has been introduced and referred to Senate Committee on Highways and Motor Vehicles. **Oppose.**

**S. B. 157** — To remove relatives' liability for support of patients in mental hospitals or benevolent institutions under the control of the Department of Mental Hygiene and Correction, has been introduced and referred to the Senate Committee on State Government. **Oppose.**

**S. B. 165** — To also restrict driver licenses to be granted under certain conditions to a person who has been adjudged mentally ill. **Oppose.**

**S. B. 197** — To provide for the mandatory licensing of nurses and practical nurses, and to repeal the present law regulating the practice of nursing, which is to an extent permissive with regard to licensure. **Oppose.**

### **Ohio Physicians Are Certified By Pathology Board**

Following are the names of Ohio physicians recently certified as diplomates of the American Board of Pathology:

Huseyin Sarikaya, Canton; Joseph O. Dean, Jr., Canton; Charles R. Key, Cincinnati; Miguel A. Dominguez, Cleveland; Hugh F. McCorkle, Cleveland; Shan A. Mohammed, Cleveland; Thomas D. Stevenson, Columbus; Hugh B. Foley, Elyria; Harley D. Lindquist, Mansfield; Jack Paston, Springfield; John E. Fales, Toledo; Daniel R. Rigal, Toledo; Ronald Chapnick, Willoughby; and James R. Hill, Youngstown.

### **Famed Burma Surgeon Is Dead at 68**

Dr. Gordon Seagrave, famed missionary doctor for some 44 years, died recently at the age of 68 in Namkham hospital.

Author of the best-seller book *Burma Surgeon*, he was one of a family of missionaries who served for more than 130 years in the Burma area.

Dr. Seagrave was known to a number of physicians in Ohio where he visited on trips to the United States.

## **Health Association Program Scheduled in Dayton**

The Ohio Public Health Association is joining with the American Public Health Association in sponsoring a program in Dayton, May 18-20. Registration begins at 6:00 p. m. on Tuesday, May 18, in the Biltmore Hotel, downtown Dayton.

Designated as "The World's Fair of Health," keynote speaker for the occasion will be John Hanlon, director of health, Detroit, Wayne County, Mich.

Among other topics and speakers will be the following:

"The Plan of the Next Years in the Health of Ohio," Dr. Emmett W. Arnold, Columbus, director of the Ohio Department of Health.

"Economic Opportunity Act," Stanley Salett.

"Mental Health, Patient, Family and Environment," Dr. M. T. Faruki, director, Dayton State Hospital.

"Role of Automation in Heart Research," Dr. Douglas Talbott, director, Cox Coronary Heart Institute.

## **Clevelanders Publish Study On Illness in the Home**

A 10-year study of some 25,000 illnesses in a group of Cleveland families has been recorded in a volume *Illness In the Home* just published by the Western Reserve University Press, Cleveland (416 pp., \$8.50).

Authors are Dr. John H. Dingle, professor of preventive medicine, and Dr. George F. Badger, professor of biostatistics, both of the Western Reserve University School of Medicine, and Dr. William S. Jordan, Jr., now professor of preventive medicine, University of Virginia, and formerly of the WRU medical faculty.

A total of 86 families embracing 443 individuals were in the study which was carried on between January 1, 1948 and May 31, 1957. In each family the mother served as the recorder of illnesses, reporting weekly. Family size varied from parents with one child to parents of six. Variation in size also occurred during the study as children were born to parents in the group.

Number of illnesses average 9.4 per person per year, indicating that most of them were of a nature unlikely to require professional attention. Sixty per cent of all illnesses were classified as "common respiratory diseases" and another three per cent as specific respiratory diseases. Infectious gastroenteritis accounted for 16 per cent of the reported illnesses occurring about three times per person in two years on an average.

# Premarital Examination . . .

## Statement Concerning Importance of Examination with Comments on Responsibility of Physicians under Law

THE Ohio Law requires that each person desiring to be married must submit to an examination by a physician to determine the presence or absence of contagious syphilis.

The Law further states that this examination must include a serological blood test for syphilis. This does not mean that the blood test, without the examination, meets the requirements of the Law.

The House of Delegates of the Ohio State Medical Association has passed a resolution which reads in part . . . "contagious syphilis can be present while a serological blood test is negative . . ." This resolution urges physicians to examine all persons requesting the premarital blood test. The intent being that the blood test is not enough to determine the presence of contagious syphilis.

The Premarital Examination Law in Ohio was instituted in 1941 primarily as a casefinding mechanism for the control of syphilis. With the rising venereal rates in Ohio, the Law is still an important factor in detecting and controlling syphilis.

### Importance of Law

However, the importance of the Law goes further than just the detection of disease.

The premarital examination given by the physician can result in the detection of physical abnormalities and the determination of fitness for marriage, as well as providing an excellent opportunity for premarriage counseling.

The March 21, 1964, issue of *The Journal of American Medical Association* carries an article which states that the skirting of state laws which require premarital blood tests and physical examinations is a factor in the nation's raising divorce rate and increased incidence of venereal disease.

An editorial in the same issue of *JAMA* states that sociologists and psychiatrists point to sexual irresponsibility, ignorance and maladjustment as the major factors underlying the instability and unhappiness of many young married couples today. The editorial further points out that premarital laws provide the legal machinery to bring young people to the physician before marriage, at a time when ignorance and fear about sex can be evaluated most easily and hopefully overcome.

### A Critical Study

In a five year study of 2500 private patients in Michigan it was found that only 35 per cent of the

women surveyed had received a physical examination in addition to the blood test. The survey also showed that 20 per cent had obtained a "bootleg" certificate attesting to a blood test and physical examination which was not signed by a doctor of medicine or osteopathic physician and surgeon as required by law.

Dr. Sylvester W. Trythall, a Detroit gynecologist, who conducted the study, says "It is quite clear from these statistics that some examiners in Michigan are not complying with the law, no doubt in the majority of cases, because neither the patient nor examiner is aware that a physical examination for both premarital partners is a requirement."

This does not mean that the same situation exists in Ohio (or any of the 37 other states that require physical examinations and blood tests), although there is quite possibly widespread ignorance of the law in Ohio.

The examining physician must be made aware of the value of the premarital examination and the public must be made aware of the need for it.

The *JAMA* editorial states that premarital blood test laws, even though costly and inadequate in the battle against venereal disease, at least provide an opportunity for those best qualified to practice preventive medicine.

Nearly 160,000 persons will be applying for marriage licenses in Ohio during 1965. The premarital examination is most certainly important to them.

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### Reminder on Names of Buildings At OSU Medical Center

Although the changes have been in effect for some time, the new names of two buildings in the medical center complex at Ohio State University still cause some difficulties to persons seeking directions or in the direction of mail.

Upham Hall is the name of the building which used to be called Columbus Receiving Hospital, psychiatric hospital, Institute for Psychiatry or Psychiatric Institute. Upham Hall houses the Department of Psychiatry and the Psychiatric Unit of University Hospitals.

Dodd Hall is the name of the building formerly known as the Ohio Rehabilitation Center. Dodd Hall houses the Department of Physical Medicine and Rehabilitation.



# New—in the OSMA Office

## Program Board Pinpoints Activities Teletype Speeds Communications

Two new items of equipment, designed to produce greater efficiency, have been added to the Ohio State Medical Association office recently. The program board pictured below, is designed to better inform OSMA members and other visitors regarding the various activities of the House of Delegates, The Council, the principal officers, the OSMA delegation to the AMA and the twenty-seven OSMA Committees. The teletypewriter or TWX machine is aimed at speeding communications between the OSMA office and the AMA headquarters in Chicago, as well as the other participating state medical society offices.

### TWX

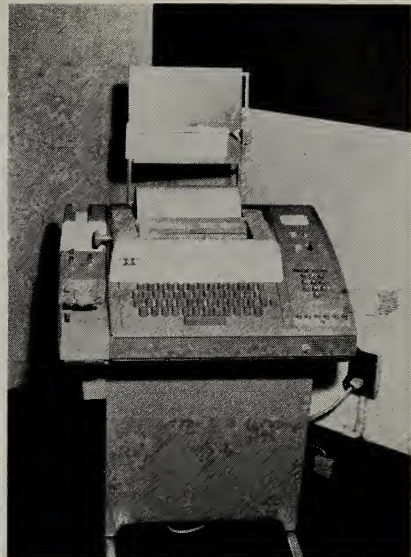
The teletypewriter was installed in the OSMA office in the early stages of the Eldercare campaign. By mid-January, the TWX network was operative in 37 states and

the District of Columbia. Virtually all states are now participating.

The AMA's Board of Trustees took the proposal for this network under consideration last June, and it was approved by the House of Delegates at the 1964 Clinical Convention in Miami. Advantages of this system over telephone conversations include speed of communications and a reduction of cost.

The AMA paid the equipment installation costs for its Chicago headquarters and offices of participating state medical societies. Rental costs also will be paid by the AMA. Whichever organization sends a message will pay for it.

The speed with which the OSMA office has been able to respond to the fast-breaking events surrounding the "Eldercare" campaign is due, in a large degree, to this TWX network. It has been possible for



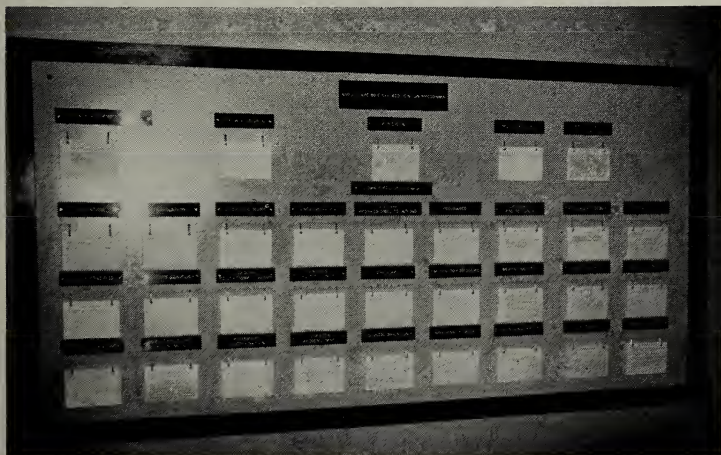
This teletypewriter recently installed in the OSMA Headquarters office speeds communications with the AMA and other medical organization facilities, at reduced costs.

OSMA to receive a request for information or material and, in the same day, forward this request to the AMA in Chicago and have the order filled and shipped or the question answered. The AMA has been able to disseminate information vital to the success of this campaign much more rapidly than previously.

### Program Board

In order to keep officers, members and other visitors better informed as to the activities, both current and upcoming, of the governing bodies and committees of OSMA, the committee board was constructed and placed just outside the OSMA meeting room. The activities of each committee, The Council, the President, the President-Elect, the House of Delegates and the OSMA Delegation to the AMA are listed on removable five by seven inch cards. These cards are continuously brought up to date.

Physicians assigned to most of the committees are listed on the roster page headed "State Association Officers and Committeemen" running in current issues of *The Journal*. Each member of the OSMA executive staff is designated as secretary of several of the committees, assisted by a member of the secretarial staff.



This new Program Board in the OSMA Headquarters office pinpoints activities of the officers, the House of Delegates and The Council and gives a clue to the numerous professional programs that are being carried on, mostly behind the scenes by the Association.

# The Congress and Medicare . . .

## A Summary of Provisions of the House-Passed H. R. 6675; How Ohio Congressmen Voted; Now Awaiting Senate Action

SENATE action on the House-passed Medicare bill (H. R. 6675) is expected sometime in late May or early June. The House passed the legislation to provide federal health care for the aged April 8. The bill goes much farther than the King-Anderson Bill originally requested by the Johnson administration.

The key House vote as far as the King-Anderson provision was concerned was on substitution of a Republican insurance plan which included some features of Eldercare which was sponsored by the American Medical Association. The vote was 236 to 191 against the GOP substitute.

With open public hearings promised by the Senate Finance Committee Chairman, Senator Harry Byrd, of Virginia, medicine will have another opportunity to present its case against this dangerous, socialistic legislation. Ohio physicians and friends of medicine should seize this opportunity and write, telegraph, telephone or call in person to convince Ohio's Senators Lausche and Young that this is a bad bill, that it is fantastically expensive (\$6 billion plus), that it benefits the millionaire as much as the needy, that it increases tremendously the Social Security taxes the working family head must pay.

Members of the Senate Finance Committee are (Democrats) Senator Byrd, Senators Russell B. Long, (La.), George A. Smathers (Fla.), Clinton P. Anderson (N. M.), Paul H. Douglas (Ill.), Albert Gore (Tenn.), Herman E. Talmadge (Ga.), Eugene J. McCarthy (Minn.), R. Vance Hartke (Ind.), J. William Fulbright (Ark.), Abraham Ribicoff (Conn.), and (Republicans) John J. Williams (Del.), Frank Carlson (Kan.), Wallace Bennett (Utah), Carl T. Curtis (Neb.), Thruston B. Morton (Ky.) and Everett M. Dirksen (Ill.)

Address Senators: Senator (full name), United States Senate, Washington, D. C., 20025.

### How Ohioans Voted

Here is how Ohio Congressmen voted on the AMA-supported motion to return the bill to the Ways and Means Committee:

Democrats for: none; against: Feighan, Gilligan,

Hays, Kirwin, Love, Moeller, Secrest, Sweeney, Vanik; not voting — Ashley.

Republicans for: Ashbrook, Betts, Bolton, Bow, Brown, Clancy, Devine, Harsha, Latta, McCulloch, Minshall, Mosher and Stanton.

Republicans against: Ayres.

Here's how Ohio Congressmen voted on passage of H. R. 6675: Democrats for: Feighan, Gilligan, Hays, Kirwin, Love, Moeller, Secrest, Sweeney and Vanik; not voting — Ashley; Democrats against passage: none.

Republicans for passage: Ayres, Bow, McCulloch, Minshall, Mosher and Stanton.

Republicans against passage: Ashbrook, Betts, Bolton, Brown, Clancy, Devine, Harsha and Latta.

The vote on final House passage of H. R. 6675 was 313 for and 115 against.

After nearly two months of hearings behind closed doors, the House Ways and Means Committee on March 23 approved the "three-layer cake" program which included a modified version of the King-Anderson bill, a supplementary government-subsidized health insurance plan for the elderly and an extensive expansion of the federal-state Kerr-Mills Program.

The committee vote was strictly on party lines — 17 Democrats for the catch-all package and eight Republicans against it. Congressman Vanik (D-21st Ohio District) voted for the bill and Congressman Betts (R-Eighth Ohio District) voted against the bill in committee.

As passed by the House, the bill excludes payment for in-hospital professional services of physiatrists, pathologists, radiologists and anesthesiologists. However, the American Hospital Association has stated it will fight for restoration of payment for these services in the Senate, so that they will be included in setting hospital charges for medicare patients.

Despite a tremendous flood of letters from the public in favor of the AMA's Eldercare plan for comprehensive health insurance for the elderly under Kerr-Mills, the House committee didn't take a vote on H. R. 3727 — the Herlong-Curtis Eldercare bill.

The Administration-approved legislation would



The tax rate on the new wage bases would be increased as follows under the proposed H. R. 6675:

	SELF-EMPLOYED		EMPLOYEE-EMPLOYER (EACH)		TOTAL
	PRESENT	PROPOSED	PRESENT	PROPOSED	
1966 .....	6.2%	6.35%	4.125%	4.35%	8.70%
1967 .....	6.2%	6.50%	4.125%	4.50%	9.00
1968 .....	6.9%	6.50%	4.625%	4.50%	9.00
1969-72 .....		7.1%		4.90%	9.80
1973-75 .....		7.55%		5.35%	10.70
1976-79 .....		7.60%		5.40%	10.80
1980-86 .....		7.70%		5.50%	11.00
1987 and thereafter ....		7.80%		5.60%	11.12

provide compulsory social security coverage, effective January 1, 1966, for self-employed physicians and for interns and residents.

#### Would Hike Cash Benefits

It also would increase, retroactive to January 1, 1965, social security cash benefits by seven per cent across-the-board with a minimum increase of \$4 a month for an individual.

The wage base on which social security taxes are paid would be increased January 1, 1966, from \$4800 to \$5600, and January 1, 1971, to \$6600.

The tax rate on the new wage bases would be increased as shown in the accompanying table.

The social security tax paid by employees and employers each would be increased next January 1 from the present \$174 per year to \$243.60. The tax on a self-employed individual would be increased from \$259.20 to \$355.60.

In 1971, when the taxable wage base would be increased to \$6600, the employee and employer would be paying a tax of \$323.40 each, and the self employed individual would be paying a tax of \$468.60.

The legislation would provide:

#### King-Anderson Section

Eligible: Persons 65 years and older.

Benefits: Inpatient hospital services for up to 60 days in semiprivate accommodations (two- to four-bed) during a spell of illness, subject to a deductible, which until 1969 would amount to \$40.

Post-hospital extended care services for up to 20 days during any spell of illness in a facility which has in effect a transfer agreement with one or more hospitals or which a state agency finds has attempted to enter into such an agreement. This benefit could be extended for a period of up to an additional 80 days under circumstances described below.

Post-hospital home health services for up to 100 visits during a one-year period following hospitalization.

Outpatient hospital diagnostic services during a 20-day period subject to a deductible equal to one-half the deductible for inpatient hospital services.

Inpatient hospital services, post-hospital home health services, and outpatient hospital diagnostic services would begin in July 1, 1966. Post-hospital extended care services would begin on January 1, 1967.

#### Supplementary Insurance

Eligible: Persons 65 years and older.

Cost to beneficiary: \$3.00 a month, first \$50 of medical bills covered and 20 per cent of total above \$50.

Benefits: Payment to the individual or to the provider of services for: (a) physicians' services, and (b) medical and other health services other than those by a provider of services as defined in the bill;

Payments to providers of services for: (a) inpatient psychiatric hospital services for up to 60 days during a spell of illness, (b) home health services for up to 100 visits during a calendar year, and (c) medical and other health services furnished by a provider of services or by others under arrangements.

No payment could be made under this program for any services for which the individual is entitled to have payment made under the King-Anderson section.

Administration: The secretary of Health, Education and Welfare would have to enter into contracts with carriers to administer the program.

#### Expanded Kerr-Mills

This program would combine all the vendor medical provisions for the blind, disabled and families with dependent children under a uniform program and matching formula. The federal matching share for cash payments for these needy persons would also be increased; services for maternal and child health, crippled children and the mentally retarded would be expanded; a five-year program of "special project grants" to provide comprehensive health care and services for needy children of school age, or preschool, would be authorized; and present limitations on federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions.

# Student Lectures . . .

## Committee on Rural Health Scores Outstanding Success at Its 1965 Talks to Medical Students

THE 1965 edition of the student lecture program, "When You Begin Practice," was again an outstanding success both at the Ohio State University and at the University of Cincinnati.

This series of special talks, sponsored by the OSMA Committee on Rural Health in cooperation with the colleges of medicine and their campus chapters of the Student American Medical Association is primarily designed to acquaint junior and senior medical students with the practice of medicine in smaller cities and towns and in rural areas. The talks include information on the medical, legal and economic aspects that these future doctors will face when they begin practice.

Nearly 375 junior and senior medical students and their wives or fiancées attended the program and banquet at The Ohio Union, Ohio State University. There were 152 junior medical students and wives or fiancées attending the program and banquet at the Cincinnati Academy of Medicine for the University of Cincinnati College of Medicine students.

### Of Long Standing

This year's program at the Ohio State University on February 6, marked the 14th time these lectures have been at this school. February 14, marked the 13th time this program has been conducted for the University of Cincinnati medical students.

The banquet to which the students and their guests were invited, was followed by three informal talks.



*Principal speakers at the evening program of the Lectures are shown from the left: Dr. Reibeld, Dr. Tschantz and Mrs. Frederick.*

Mrs. Victor R. Frederick, Urbana, a past-president of the Woman's Auxiliary to the OSMA, spoke on the topic, "The Physician's Wife." Robert E. Reibeld, M. D., Orrville, spoke on "The Physician and His Community." At the Ohio State University, OSMA Past-President Horatio T. Pease, M. D., of Wadsworth, talked on the subject, "The Physician and His Medical Society." Robert E. Tschantz, M. D., President of OSMA, from Canton, spoke on the same subject at the University of Cincinnati.

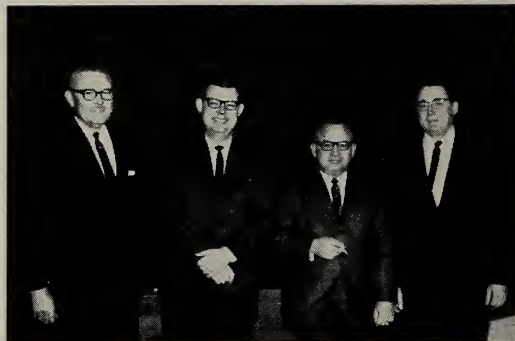
A fourth speaker at the Ohio State dinner was Dr. J. Hutchison Williams, Assistant Dean of the College of Medicine.

Tenth District Councilor Richard L. Fulton, M. D., presided at Ohio State and First District Councilor Robert E. Howard, M. D., presided at Cincinnati.

### More Phases Covered

The afternoon program at both schools included speeches on "The Family Physician: His Practice" by Victor R. Frederick, M. D., Urbana; "Economics of Medical Practice," by Charles H. McMullen, M. D., Loudonville; "The Art of Medicine," by J. Martin Byers, M. D., Greenfield; and "Preceptorships for Medical Students," by Jasper M. Hedges, M. D., Circleville.

As has been the custom for the past several years, a stipend was presented on behalf of OSMA to assist the campus Student AMA Chapter presidents in attending the national Student AMA Annual



*Speakers who participated in the afternoon programs are from the left: Dr. Frederick, Dr. McMullen, Dr. Hedges and Dr. Byers.*



Meeting. Receiving the stipend at OSU was chapter president William H. Montgomery. Lawrence J. Fenton, president of the Cincinnati chapter, received the check at that school.

An added feature of the program this year was that of having a medical student at each school relate some of his experiences as well as giving his impression of the OSMA preceptorship program. Mr. James F. Hamilton, fourth year medical student, spoke at OSU and Mr. Fred Rosewater, fourth year student, spoke at the University of Cincinnati.

Refer to the April issue of *The Journal*, page 384 for the text of one of these informal talks.

#### Other Features

The annual banquet and lecture program for medical students is just one of the continuous activities of the OSMA Committee on Rural Health to interest future physicians in the rural practice of medicine.

The Committee sponsors and administers the OSMA's Rural Medical Scholarships. Two scholarships are awarded each year. Each recipient receives \$500 annually for each of his four years in the medical school of his choice. It is the hope of the Committee that winners of the scholarships will return to rural areas to set up practice.

The Committee also sponsors a preceptorship program, whereby junior medical students spend one to two weeks with a general practitioner.

### VA Announces Revision in Formulary on Drugs

The Veterans Administration announced that it is updating its pharmaceutical "formulary system" policy to bring it into line with recommendations made by the American Medical Association, American Pharmaceutical Association, American Hospital Association, and American Society of Hospital Pharmacists in their revised "statement of guiding principles."

VA will discontinue the previous AHA-ASHP procedure in effect in VA since 1963 whereby physicians gave blanket prior authorization for the dispensing of alternate brands or "equivalent" non-proprietary-name drugs. In the future it will adopt a system approved by the four organizations during the past year. This provides for the physician, at the time of prescribing, to approve or disapprove the dispensing of alternate brands if he chooses to do so. It also provides for the appraisal and use of drugs not included in the formulary.

Private physicians treating VA outpatients also will be asked to follow the new system, but only when the prescriptions are to be dispensed by VA pharmacies.

The procedure does not apply when prescriptions are to be dispensed by community pharmacies participating in the "hometown" pharmacy program, VA officials said.

### Camera Catches Highlights In Student Lectures



*OSMA President Robert E. Tschantz, left, is shown presenting a check to Lawrence J. Fenton, president of University of Cincinnati Chapter of the Student AMA. This gift helps student officers to attend national SAMA meeting.*



*OSMA Past-President Horatio T. Pease, right, is pictured presenting a check to William H. Montgomery, president of the OSU Chapter of SAMA.*

### Ohio Medical Golf Tournament Scheduled at Lorain Club

The 45th annual tournament of the Ohio State Medical Golfers Association is scheduled at the Oak Hills Country Club, Lorain, on Thursday, June 10. Teeoff time is from 9:00 a. m. A buffet luncheon will be served at the club, where the annual banquet also will be held beginning about 7:00 p. m.

Tournament chairman is Dr. Lewis Hait, Lorain. Physicians interested in the tournament, as well as members of standing with the group, are invited to contact Mr. Robert W. Elwell, Executive Secretary of the Academy of Medicine of Toledo, 3101 Colliwood Blvd., Toledo.

# "Medicine and the Whole Man". . .

Portrayed in This Theme of the 1965 OSMA Annual Meeting Is  
A Program in Columbus, May 9-14 for Every Ohio Physician

**P**LANNERS of the 1965 Ohio State Medical Association Annual Meeting have reached far and wide to bring to Ohio physicians leaders in the professional field and to present a program that comprises more than 50 hours of scientific sessions. The theme of the program is "Medicine and the Whole Man."

Dates for the program are Sunday, May 9, through Friday, May 14, with the program of the American Academy of Pediatrics, Ohio Chapter, extending into Saturday.

Following is a summary of features:

**Ohio Academy of Medical History**, meeting beginning at 10:00 a. m. Sunday, May 9, in the Columbus Plaza Hotel.

**OSMA House of Delegates**, first session begins with dinner on Sunday at the Columbus Plaza Hotel. Second session on Tuesday, again begins with a dinner at 6:00 p. m. Reference committees of the House meet on Monday, and if necessary on Tuesday; all meetings in the Columbus Plaza Hotel.

**Ohio State Surgical Association** scientific program and business meeting, beginning at 2:00 p. m. on Monday in the Columbus Plaza Hotel.

**Medical Motion Pictures** will be shown on Tuesday, May 11, in the Columbus Plaza Hotel beginning at 9:00 a. m.

**Registration:** Headquarters for Registration, the West Entrance Lobby, Ground Floor of the Veterans Memorial Building, 300 W. Broad Street, Columbus, opening on Tuesday, May 11, at noon. Registration will be open on Wednesday and Thursday from 9:00 a. m. to 5:30 p. m., and on Friday from 9:00 a. m. to 2:00 p. m. Special provisions will be made to register persons attending sessions of the House of Delegates and its Reference Committee meetings.

Those eligible to register are members of the Ohio State Medical Association (who should present 1965 Membership Cards at time of registration); physicians from other states who are members of their respective state medical associations; residents, interns and medical students; nurses, health workers and others who are presented as guests at Registration Headquarters by members. Letters of introduction on members' stationery also will be honored at Registration Headquarters.

**Scientific and Technical Exhibits** open at noon on Tuesday, May 11, in the Veterans Memorial Building. The exhibit floor will be open on Tuesday from noon to 5:30 p. m.; on Wednesday and Thursday from 9:00 a. m. to 5:30 p. m.; and on Friday from 9:00 a. m. to 2:00 p. m. Ample recesses will be scheduled during the program for members to visit the exhibits often.

**Scientific Sessions.** With the exception of the Ohio State Surgical Association program on Monday afternoon, scientific sessions begin on Tuesday afternoon, for the most part in the Veterans Memorial Building. Consult the March issue of *The Journal* for details of the program, names of speakers, topics, times and places; also the Official Call mailed to each member of the Association.

**Specialty Societies.** A number of Specialty organizations are cooperating in sponsoring the program. Some are presenting their own programs while others are combining their programs with those of the Specialty Sections. A review of the program will show time and place of these jointly sponsored features.

**President's Reception** to be held on Wednesday evening from 6:00 to 8:00 p. m. will be the social highlight of the Annual Meeting. This is to be a congenial gathering without a fixed program and without a dinner. All members and their guests are invited and the Association will furnish hors d'oeuvres. For those who wish cocktails, a cash bar will be available. Dancing may be enjoyed by all to the accompaniment of music by Chuck Selby and his orchestra. Dress is optional.

**The Woman's Auxiliary** will meet in the Christopher Inn at 300 East Broad Street in downtown Columbus. The ladies will provide registration facilities in the Christopher Inn for their members and for all persons eligible for membership.

**Emergency Telephone Service** will be furnished during periods when program features are in progress by the Academy of Medicine of Columbus and Franklin County. A booth will be set up in the Veterans Memorial Building with the special telephone number 244-3664. It is recommended that physicians who expect urgent calls leave information at this booth as to where they can be reached. The usual procedure is for names of physicians called to be placed on a bulletin board near the information booth.



## Leading Downtown Columbus Hotels and Prevailing Rates

### COLUMBUS PLAZA HOTEL (Headquarters)

50 N. Third Street

Singles ..... \$11.50 - 15.50

Twins ..... 14.00 - 19.00

### DESHLER-COLE HOTEL

W. Broad & N. High Streets

Singles ..... \$ 7.50 - 14.50

Doubles ..... 12.00 - 18.00

Twins ..... 13.00 - 20.00

### NEIL HOUSE

41 So. High Street

Singles ..... \$ 8.50 - 15.00

Doubles ..... 12.00 - 18.00

Twins ..... 12.00 - 20.00

### HOTEL SOUTHERN

So. High & E. Main Streets

Singles ..... \$ 8.00 - 8.50

Doubles ..... 11.00 - 11.50

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Ohio State Medical Association

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# AMA New York Convention . . .

Here Are Highlights of the Comprehensive Program;  
Dates, June 20-24; Time Now To Make Reservations

ONE OF THE LARGEST GROUPS of physicians in history is expected to converge on New York City June 20-24 for the 114th Annual Convention of the American Medical Association. With the Convention located conveniently in regard to this State, a large number of physicians from Ohio will attend and many are expected to take their families.

Ohio physicians are advised to send in the pre-registration forms and the hotel or motel reservation forms appearing in current AMA publications.

Physicians who attend the Convention will be a part of one of the most outstanding scientific programs ever presented. The chairman of the AMA Council on Postgraduate Programs, Gilson Colby Engel, M. D., of Philadelphia, explained that members of the Council and representatives of the AMA's scientific sections have compiled a program designed to provide information which will benefit all physicians, including general practitioners and specialists in all types of practice.

Features of the meeting will be six general scientific sessions, coordinated by the secretaries of the AMA sections. Topics will include metabolism in growth development and aging, non-narcotic drug addiction, adverse drug reactions, hearing, organ transplantation, diagnostic cytology, and many other subjects of interest to the physician in everyday practice.

Also some 60 reports on recent research developments will be given during the fifth Multiple Discipline Research Forum, which will be presented as a program of the Section of Experimental Medicine and Therapeutics.

## Exhibits

More than 350 scientific exhibits, some designed to instruct the physician and others to report on results of recent investigation, will be housed in the New York Coliseum, which also will be the site of many of the scientific sessions and the medical motion picture and television programs.

An example of the excellence of this year's scientific program will be found in the portion of the program conducted by the Section on General Surgery. This program, which includes many of the nation's best known surgeons, features symposiums on breast cancer, diseases of the pancreas, biliary

tract disease, diseases of the parathyroid, nodular diseases of the thyroid gland, and many others.

## Auxiliary Meeting

The Woman's Auxiliary to the AMA is holding its annual meeting in New York during the same week as that of the AMA Convention. Headquarters for the Auxiliary will be the Americana Hotel.

With Mrs. William H. Evans, of Youngstown, as president of the Auxiliary, this year's program will be of special significance to the ladies of Ohio.

## For the Youngsters

Special provision has been made this year for the children of members who attend the New York Convention. Special guided tours and other entertainment features have been scheduled for pre-teens and for teen-agers. More details on these features will be printed in AMA publications.

## Program To Be Published

The May 10 issue of *The Journal of the AMA* will have the complete program of the 114th Annual Convention. Readers are urged to scan this program carefully for speakers and subjects in which they are interested and to note the time and place of these program features.

## Ohio Hospital Association Names New Associate Director

Pursuant to action of the OHA board of trustees, to implement a program for coordination of planning for health facilities, Edward A. Lentz has been appointed associate director of the Ohio Hospital Association.

Mr. Lentz has been assistant director of the Columbus Hospital Federation. He is a graduate of the University of Cincinnati and earned a Master's degree from Wayne State University. He is presently assistant professor of preventive medicine at Ohio State University, in addition to his other duties.

Mr. Lentz will be responsible for the expanded statewide program of consultation with and coordination of various regional health facility planning organizations in Ohio, and coordination of Ohio planning activities with other states. Purpose of the new program will be to promote orderly development of hospitals and related health facilities.

Donald R. Newkirk is executive director of OHA.



# OSMA Major Medical Insurance . . .

## First Year of Actual Experience on Claims Paid Shows That Plan Was Much Needed in This State

**A**CTUAL experience under the Major Medical insurance program for Ohio doctors sponsored by the Ohio State Medical Association, during its first year of operation, has clearly proven that it was much needed.

Claims paid to insured members range from a token payment of \$9.00 up to a maximum payment (during the first year) of \$8,776. At this point it should be made clear that the benefit period for an individual illness or injury can extend for as long as three years and, therefore, in many cases amounts paid to claimants during the first year will be greatly exceeded during the remainder of the potential three year period.

Claims paid to date in excess of \$1,000 constituted slightly in excess of 60 per cent of all claims paid. Claims paid in the amount of \$2,500 or more constituted approximately 30 per cent of all claims.

Claims paid during the first year exceeding \$5,000 represented approximately 10 per cent of the total number of claims handled.

Again, it must be noted that claim periods can last up to three years and with only one year's experience, total amounts paid will in many cases exceed the figures represented by the first year's activities.

As might be expected, heart attacks and cardiovascular illnesses produced the greatest percentage of claims followed by various forms of cancer, accidents and mental illnesses. Diabetes produced a number of large claims.

It is interesting to note that in approximately 25 per cent of all claim cases, treatment was sought at a hospital located outside the state of Ohio. A considerable amount of claims were paid for sanatoriums or other specialized facilities of the type not normally covered by basic hospitalization policies.

In view of the fact that a very high percentage of children were covered in the policies originally issued, it would be expected that a rather good percentage of claims would have arisen because of treatment of children. Yet, the fact that as one ages he is generally subject to more risk of illness and longer periods of treatment no doubt accounts for the fact that 64 per cent of all claims involve the doctor himself. 30 per cent of claims submitted

involve the spouse and only 6 per cent involve the children. However, it should be noted that one of the claims involving children has already caused payments in excess of \$3,000 with apparently many additional claims dollars to be paid in the future in this case.

A most significant statistic involving Ohio doctors is the apparent average length of disability, which is 4.3 months.

Of claims processed to date, an even more significant 21 per cent involve apparently continuing periods of disability, which already average 9.2 months in duration. These facts indicate a strong and definite need for full disability income protection on the part of Ohio doctors.

Eighty-seven per cent of all claims have involved sickness. In many cases that sickness existed in some form prior to issuance of this insurance protection. Thirteen per cent of claims involve accidents, the most severe of which to date has involved payment of claims in excess of \$8,000 with the case not yet closed.

Of those incurring Major Medical expenses and on claim, 1 out of 12 has been subjected to two or more different types of illnesses or injuries which in each case has caused expense sufficiently great to produce two or more paid claims.

Private nursing care involving use of registered or practical nurses was utilized in 45 per cent of all claims. Expenses thus far paid for such private nursing care have ranged up to a high of over \$6,000. In that case most of the private nursing care was provided during an extended convalescence in the home. This is an example of the type of protection provided only by a broad Major Medical program such as that sponsored by the Ohio State Medical Association.

As of the end of the year, 70 per cent of all claims paid have involved hospital charges, including fees paid for Professional Services rendered in the hospital. Eleven per cent of claims have been paid for out of hospital expenses other than private nursing care and 19 per cent have been paid for private nursing care both in and out of the hospital.

At the end of the year over 2,100 Ohio doctors had protected themselves with this program. Unfortunately, many of those not yet protected could

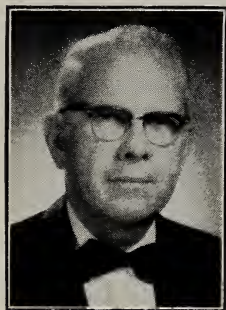
well have used this insurance during the year just past and will undoubtedly find need for it in the future. It is hoped that many not yet covered will apply for this most important insurance. All members of the Association under the age of 60 and in good health are eligible to apply now.

Daniels-Head & Associates, Inc., administer this program for the Ohio State Medical Association.

## New Titles Are Designated for Member of Journal Staff

The Council of the Ohio State Medical Association at its recent meeting designated new titles for a member of *The Ohio State Medical Journal* when it named R. Gordon Moore as Executive Editor and Executive Business Manager.

A member of *The Journal* staff since 1948, Mr. Moore is a graduate of Louisiana State University with the degree of B. A. in Journalism, and formerly was editor and reporter in the weekly and daily newspaper field. When he



Gordon Moore

joined the staff he became the first member of the executive personnel to work full time on *The Journal*. His former titles were those of News Editor, Assistant Managing Editor and Assistant Business Manager.

*The Journal* is the official publication of the Ohio State Medical Association and is published under direction of The Council. As

Executive Secretary of the Association, Hart F. Page is Managing Editor and Business Manager of *The Journal* in addition to his other responsibilities. Perry R. Ayres, M. D., practicing physician of Columbus, is Editor of *The Journal*, and is responsible for selecting and editing articles for the Scientific Section as well as exercising general supervision over all medical aspects of the publication.

## Cleveland VA Unit Will Have Artificial Kidney Center

One of three new VA artificial kidney centers is being built in Cleveland, according to an announcement from the Veterans Administration.

Four similar centers are now in operation at various installations throughout the country. With the additional units, it will be possible to accommodate and rehabilitate about 235 veterans, VA reported.

A VA study indicates that nine out of ten of the patients who have been treated once or twice weekly at the artificial kidney centers for a year or more are able to live active lives at home while 50 per cent have earning capacities equal to or greater than they did at the onset of their illness.

## At Fairfield County Program



Dr. Edward R. Annis (right), past-president of the American Medical Association, is shown with Dr. V. A. Simiele, Fairfield County Medical Society president, when Dr. Annis was in Lancaster April 4 to speak on Eldercare before a public meeting sponsored by the Fairfield County Society and attended by nearly 500 persons.

"We doctors believe it is unfair to tax young workers for 40 years to provide service for all people over 65," Dr. Annis told his audience. He emphasized that the medical profession believes in helping those who need help. The Miami, Fla., surgeon was guest of honor at a dinner presented by the society following his afternoon address.

## Certificates of Vaccination For Travelers Abroad

Every day hundreds of travelers run into delays in quarantine. The reason: They fail to present a valid international certificate of vaccination, states the U. S. Public Health Service.

In the United States the certificate is published as Public Health Service form 731, "International Certificates of Vaccination," revised June 1961. The form is given out with the passport application. It may also be obtained from local and State health departments or from offices of the U. S. Public Health Service. In addition, it may be bought from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, at ten cents a copy.

Dr. John B. Caughey, associate dean of Western Reserve University School of Medicine, spoke at the graduation exercises of the Central School of Practical Nursing.



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Age	INITIAL LOMOTIL LIQUID DOSAGE*
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1-2 yr. . . . .	½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . .	1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . .	1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . .	1 tsp. 5 times daily (10 mg.)
Adult . . . . .	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

\*Based on 4 cc. per average teaspoonful.

Note: After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

## LOMOTIL<sup>®</sup> TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride . . . . .	2.5 mg.
(Warning: May be habit forming)	
atropine sulfate . . . . .	0.025 mg.

### Precautions

Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

### Cautions and Side Effects

Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**SEARLE** Research in the Service of Medicine

# Ad Astra

**Howard Benus, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1912; aged 77; died March 17; member of the Ohio State Medical Association and the American Medical Association. A native of Cincinnati, Dr. Benus practiced there for more than 50 years before his retirement. He was a veteran of World War I. Survivors include his widow and two brothers.

**Jerome John Brewster, M.D.**, Cleveland; St. Louis University School of Medicine, 1930; aged 63; died March 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Brewster engaged in the general practice of medicine for some 34 years in the Cleveland area. He was a member of the Catholic Church. Survivors include his widow, two sons, five sisters and four brothers.

**Samuel Lloyd Corbin, M.D.**, Springfield; Meharry Medical College, 1936; aged 57; died March 24; member of the Ohio State Medical Association. A lifetime resident of Springfield, Dr. Corbin practiced there for many years and was active in numerous organizations and community affairs. He was a member of the Board of Trustees of Ohio University, staff physician at Wilberforce University, member of Champion Lodge of Masons and holder of several advanced degrees in Masonry; he was award winner this year for his activities in behalf of the YMCA and was a member of Trinity A. M. E. Church. Surviving are his widow, a son, a stepdaughter and a sister.

**Leon Delwin Carson, M.D.**, Akron; Northwestern University Medical School, 1925; aged 68; died on or about March 21; former member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Preventive Medicine; Fellow of the American College of Physicians. A former career medical officer in the Navy, Dr. Carson served as Summit County health commissioner with offices in Akron before he moved to Chicago in 1959.

**Frederick William Davis, M.D.**, Dayton; College of Physicians and Surgeons of Baltimore, 1905; aged 83; died December 14. Dr. Davis practiced medicine for many years in the Dayton area.

**Richard Henry Dickinson, M.D.**, Cleveland; Western Reserve University School of Medicine, 1928; aged 65; died March 6; member of the Ohio

State Medical Association and the American Medical Association. A practitioner in the Cleveland Heights area of Greater Cleveland for more than 35 years, Dr. Dickinson was affiliated with the Baptist Church and the Sons of the American Revolution. Survivors include his widow, a son and a sister.

**Fred Melvin Douglass, Jr., M.D.**, Toledo; Jefferson Medical College of Philadelphia, 1944; aged 46; died March 23; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery. Dr. Douglass some 12 years ago gave up a private surgical practice to devote full time as director of surgery for Maumee Valley Hospital. Also director of research, he pioneered in studies on therapeutic value of hyperbaric oxygen. Dr. Douglass served in the Army Medical Corps during World War II. A native of Toledo, he was the son of the late Dr. Fred M. Douglass, Sr. Surviving are his widow, a daughter and two sons.

**Samuel Epstein, M.D.**, Youngstown; Ohio State University College of Medicine, 1935; aged 54; died November 11; member of the Ohio State Medical Association and the American Medical Association. A practitioner in the Youngstown area for most of his professional career, Dr. Epstein devoted the World War II years to service in the Army Medical Corps and was assigned to the South Pacific Theater. Among affiliations, he was a member of Rodef Shalom Temple. Survivors include his widow, a daughter, a son and three brothers.

**Anthony Royce Grierson, M.D.**, Sandusky; University of Cincinnati College of Medicine, 1918; aged 73; died March 4; member of the Ohio State Medical Association and the Aerospace Medical Association. A physician, specializing in eye, ear, nose and throat practice, for many years in Sandusky, Dr. Grierson held a law degree as well as a medical degree and was a member of the Erie County Bar Association. As a veteran of World War I, he was a member of the American Legion. Other affiliations included memberships in the Presbyterian Church, and several Masonic bodies. He is survived by his widow, a daughter, a stepdaughter and a sister.

**Elton B. Gudenkauf, M.D.**, Columbus; Ohio State University College of Medicine, 1939; aged 50; died March 2. A native of Minster, where his father, the late Dr. Henry J. Gudenkauf practiced, Dr. Elton



Gudenkauf practiced in Kentucky before he moved to Columbus several years ago. He operated the Anson L. Brown Laboratories. Surviving are his widow, two sons, a daughter, a brother and a sister.

**Joseph Martin Huerkamp, M.D.,** Ft. Recovery; University of Cincinnati College of Medicine 1916; aged 74; member of the Ohio State Medical Association and the American Medical Association. Dr. Huerkamp practiced medicine for many years in the Ft. Recovery area. Information reached *The Journal* only recently that he died last year.

**Alexander Robert Johnston, M.D.,** Cincinnati; University of Cincinnati College of Medicine, 1917; aged 75; died March 23; member of the Ohio State Medical Association and the American Medical Association. A native of Antrim in Guernsey County, Dr. Johnston practiced for many years in Cincinnati. Survivors include a son and a sister.

**J. Edward Joice, Jr., M.D.,** Toledo; Meharry Medical College, 1928; aged 66; died March 12; member of the Ohio State Medical Association. On the medical staff of Toledo State Hospital for only a short time, Dr. Joice practiced for about 25 years in Warren and from 1930 to 1938 had his practice in Cleveland. He was a veteran of World War I, World War II and the Korean Conflict. He was active in a number of organizations, among them the AME Church and several Masonic bodies. Surviving are his widow, a son, a stepson, his mother and a brother.

**Clayton Charles Perry, M.D.,** Cleveland; University of Maryland School of Medicine, 1920; aged 68; died March 6; member of the Ohio State Medical Association, the American Medical Association and the American Proctologic Society; Fellow of the American College of Surgeons. A native of Pennsylvania, Dr. Perry took advance training at the Mayo Graduate School of Medicine and in London, England, before his extensive practice in Cleveland began. His practice was in the field of proctology. A veteran

of World War I, he is survived by a son, a brother and a sister.

**Elmer William Schlemmer, M.D.,** Cincinnati; University of Cincinnati College of Medicine, 1912; aged 74; died March 11; member of the Ohio State Medical Association and the American Medical Association. A career health officer, Dr. Schlemmer was associated with the Cincinnati Board of Health from 1913 until 1961, and was also physician for the City of Cincinnati.

**Abe Leon Schwartz, M.D.,** Gloucester, Virginia; University of Cincinnati College of Medicine, 1931; aged 58; died March 29; former member of the Ohio State Medical Association. Dr. Schwartz practiced in the Cincinnati area over a long period before he left the city about seven years ago. Dr. Bernard A. Schwartz, of Cincinnati, is a brother. Also surviving are his widow, a daughter, a sister and two other brothers.

**Maurice V. Sheets, M.D.,** Hollywood, Calif.; Ohio State University College of Medicine, 1934; aged 57; died March 13; former member of the Ohio State Medical Association. A practicing physician in Newcomerstown until 1942, Dr. Sheets went to the Naval Medical Corps during the war and moved his practice to Hollywood after returning from service. His widow survives.

**Bertram R. Shoemaker, M.D.,** Roseburg, Oregon; Ohio State University College of Medicine, 1911; aged 77; died recently in Oregon. A native of Ohio and graduate of an Ohio medical school, Dr. Shoemaker practiced for many years in the Oregon community where he also was health officer.

**Armine Taylor Wilson, M.D.,** Wilmington, Delaware; University of Cincinnati College of Medicine, 1936; aged 55; died December 7. After receiving his degree from the University of Cincinnati College of Medicine, Dr. Wilson left the state. For many years he was established in practice in the Wilmington area.

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# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*

— Justice Robert H. Jackson in AAA Supreme Court Case, 1942

## HOSPITAL PAUSES TO REFLECT ON PAST, PRESENT AND FUTURE

"While a centennial anniversary honors a century of service, it marks also the beginning of a new adventure. It seems most appropriate therefore to take stock of where we are and where we are going."

These are the opening words in an introduction to the centennial symposium of University Hospitals of Cleveland, scheduled for May 20-22, and written by Dr. Alan R. Moritz, committee chairman. In his further comments, he states: "To a large degree, the future function of the university hospital and its professional personnel will be determined by various scientific, economic and socio-political phenomena. While these phenomena undoubtedly will differ in many important respects from those which have shaped our development in the past, we cannot afford to ignore history when planning for the future. With this in mind, Western Reserve University joins with University Hospitals to present a Centennial Symposium which will examine the past and present, as well as the future, functions and responsibilities of the university hospital."

Congratulations go to University Hospitals and the century of progress that stands behind the present complex. Now in the midst of perhaps the greatest expansion program ever undertaken by an institution, the future will add even more contributions to medicine, to the entire hospital field and to the vast community that it serves.

## COMMUNITY HEALTH WEEK — TIME TO PLAN NOW

The period of November 7-13 has been officially designated as Community Health Week by the Board of Trustees of the American Medical Association.

The board is urging all State and County Medical Societies to encourage other members of the community health team to join with them in making plans to mark this third annual observance of Community Health Week with significant local programs.

Primary objectives of this nationwide observance are to stimulate greater public awareness and appreciation of the wealth of health facilities and services

which are available locally and to stress the health progress and medical advances which have been made locally through the concerted effort of all members of the community health team.

A good local program takes planning well in advance, appointment of committees, reservation of space, and so forth. This is the time for physicians interested in this project to contact their County Medical Societies and offer their services. Kits will be available from the AMA later in the season, but now is the time to start planning.

## THE DOCTOR-PATIENT RELATIONSHIP AND HEALTH HISTORY TAKING

The gratification that goes with the personal health history taking "is an experience that patients most often define as the single most important factor in creating a satisfactory doctor-patient relationship."

That observation is made in an article by a team from the Departments of Medicine and Psychiatry of Duke University School of Medicine published in the April 5 issue of *The Journal of the AMA*.

Noting that time obviously is an important element in modern practice, the authors disagree with the criticism that the "old personal touch" has supposedly been lost in modern American medicine. "What is needed is not less science, but more science," they observe.

What is further needed is a "precise, predictable technique . . . which will give the doctor-patient relationship the quality of closeness that proves satisfying to both patient and physician," the authors conclude.

In our opinion, the observations of the authors are well taken and further point up an important phase of public relations for the medical profession as a whole.

Obviously the physician's first consideration in every phase of practice is the good of the individual patient. In a broader sense, however, what is good for the patient is good for the doctor-patient relationship. The sum total of all doctor-patient relationships in the long run creates the "image" of the medical profession in the public mind.



# Activities of County Societies . . .

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### CLINTON

The Clinton County Medical Society met for dinner and a program on March 23 at the Clinton Memorial Hospital, Wilmington. Speaker was Dr. Joseph Wilson, of Dayton, who discussed anti-coagulant therapy.

### HAMILTON

"Psychiatric Aspects of Surgical Patients" was the topic discussed at the March 16 meeting of the Academy of Medicine of Cincinnati at the Academy headquarters. Speaker was Dr. Harold I. Lief, professor of psychiatry, Tulane University, New Orleans.

For the April 13 meeting of the Academy, guest speaker was Dr. Janet McArthur, Vincent Memorial Hospital, Boston, whose topic was "Practical Endocrinology in the Female Patient."

## Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

### ALLEN

The regular March meeting of the Lima and Allen

County Academy of Medicine was held at the Shawnee Country Club with 76 members and guests present. Dr. John Will, Director of Laboratories of Nutrition and Hematology at Cincinnati General Hospital, gave a very scholarly lecture on "Diagnosis and Management of Common and Obscure Anemias." This centered primarily on megaloblastic anemias and their complex relation to folic acid and vitamin B<sub>12</sub>. — T. D. Allison, M. D., Secretary-Treasurer.

## Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

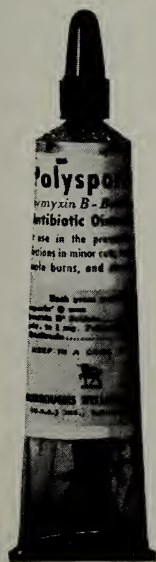
### HENRY

Dr. Thomas F. Moriarty was re-elected as president of the Henry County Medical Society at its re-organization meeting (in March).

Dr. J. J. Harrison was named vice-president and Dr. Gamble S. Hall, secretary and treasurer.

The organization named Dr. Edwin C. Winzeler as delegate from Henry County to the Ohio State Medical Association convention which will be held during May. In the event he cannot attend, Dr. Mori-

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arty was named as alternate delegate. — *Northwest Signal*, Napoleon.

## Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

### COLUMBIANA

Dr. H. Scott Vanordstrand, of Cleveland, was guest speaker at the regular March meeting of the Columbiana County Medical Society at the Wick Hotel in Salem.

### STARK

Dr. Norman H. Baker, Columbus, was speaker at the March meeting of the Stark County Medical Society at the Mergus Restaurant in Canton. His discussion was in the field of thoracic and cardiovascular surgery.

### SUMMIT

"Australian Voluntary Health Plan" was the topic discussed by Dr. Bennis E. Grable at the March 2 meeting of the Summit County Medical Society. The program was held at Children's Hospital in Akron.

### TRUMBULL

The regular meeting of the Trumbull County Medical Society was held on March 17 at the Holiday Inn, Warren, beginning with a social hour and dinner. R. J. Silman, sales manager for Eastern Airlines, presented a travelogue on the Caribbean.

During the business meeting the Eldercare program was discussed by members of the Legislative Committee.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

Dr. A. D. Ghaphery, chief surgical resident at University Medical Center, Morgantown, W. Va., spoke on the topic, "Peripheral-Arterial Disease—Its Diagnosis and Treatment," for the March 18 meeting of the Belmont County Medical Society. A joint dinner meeting with the Auxiliary was held at the Belmont Hills Country Club.

## Ninth District

(COUNCILOR: GEORGE NEWTON SPEARS, IRONTON)

### MEIGS

Dr. Gordon F. Ogram, superintendent of the Athens State Hospital, spoke at the February meeting of the Meigs County Medical Society in Pomeroy. Dr. Ogram described facilities at the hospital in Athens and presented an illustrated talk on mental illness.

## Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

### FRANKLIN

The eighth annual joint meeting of the Academy of Medicine of Columbus and Franklin County with the Columbus Bar Association was held in the Deshler-Cole Hotel on April 19.

Program speaker was Judge Earl R. Hoover, Cleveland, Common Pleas Court for Cuyahoga County.

## Eleventh District

(COUNCILOR: L. C. MEREDITH, M. D., ELYRIA)

### ERIE

The annual Ladies Night meeting of the Erie County Medical Society was held at the Holiday Inn, Sandusky, on March 30. Members of other professional groups in the area were invited guests with their ladies.

Dr. Derrick Lonsdale, Cleveland, was guest speaker and discussed the British National Health Service.

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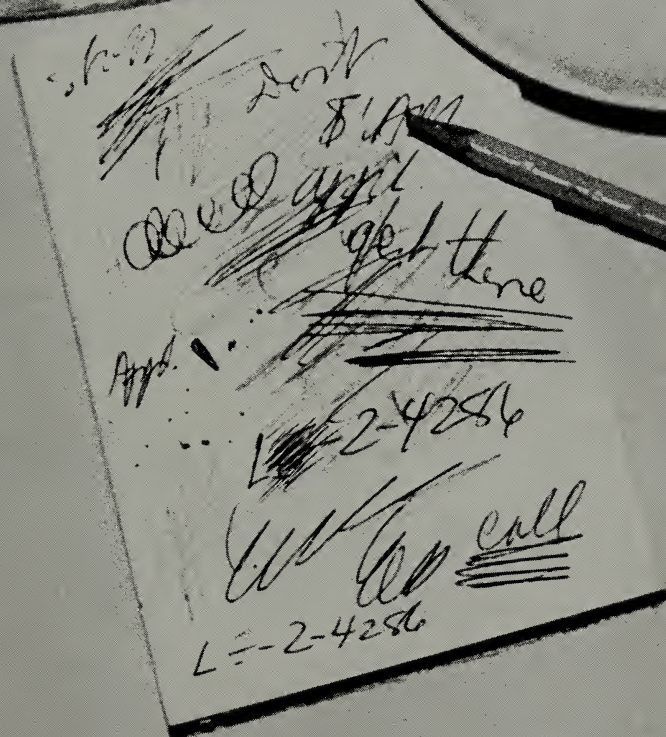
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Vitamin B <sub>6</sub> (Pyridoxine HCl)	2 mg.
Vitamin B <sub>12</sub> Crystalline	4 mcgm.
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# Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee

Chairman, 2442 Dorman Dr., Portsmouth

**A** GAINST the background of New York's skyline and the World's Fair, the forty-second annual convention of the Woman's Auxiliary to the American Medical Association will find doctors' wives "East Side, West Side, All Around the Town," between June 20 and 24. During certain designated daylight hours, most of them should be spotted at the Americana Hotel, 52nd Street and 7th Avenue, convention headquarters, for the important business sessions (with Mrs. William H. Evans, president, presiding).

But it will not be a time of all work and no play. On Sunday afternoon, June 20, there will be the annual Tea and Fashion Show, followed by a Get-Together for Auxiliary members in the hospitality room. Also on that afternoon will be the "Teen-Age Mixer." (A special Teen-Age program has been planned for the five days for the children of AMA and Auxiliary members attending the convention.) Sunday night will feature a "Gala Nite Life Party" with dinner and spectacular floor show at the glamorous Latin Quarter; a visit after that to Sammy's Bowery Follies for a Fun Gay Nineties Revue; and finally a midnight stop (if you can still navigate!) at the International Night Club.

Monday's program will feature a Guest Day luncheon for leaders of National Women's Volunteer Organizations, Auxiliary members and their guests at the Trianon Ballroom, Hotel Hilton. Tuesday's luncheon will salute the national past-presidents at which AMA officers and their wives will also be hon-

ored guests. Dr. Donovan F. Ward, President of the American Medical Association, will be the featured speaker.

The foregoing is, admittedly, but a peek into the many varied and interesting items on the agenda. More on all that next month . . .

## Heard Along the Way

Our President, Mrs. John D. Dickie, was recently presented with a "recognition pin" for over one thousand hours of service as a St. Vincent Hospital volunteer worker in Toledo. (What amazes your reporter is not that Marge was so honored, but that she has the capacity to carry double and triple the load!)

There were some one hundred banquet guests at the March meeting of the **Fairfield County Auxiliary** (held in conjunction with its Medical Society) at the Lancaster Country Club. Dr. Jack Schreiber of Canfield, a member of the AMA Speakers' Bureau, discussed Medicare versus Eldercare. He was introduced by Dr. Victor Simiele, Fairfield County Society president. Mrs. W. D. Nusbaum was program chairman, assisted by Mrs. G. B. Snider, Mrs. H. M. Amstutz and Mrs. Paul Millikan.

## "Hello Dolly"

With paper dolls on luncheon tables and living dolls (so we were told) on the runway, **Hamilton Auxiliary** members are still humming "Hello Dolly" and with good cause. The group held a most suc-



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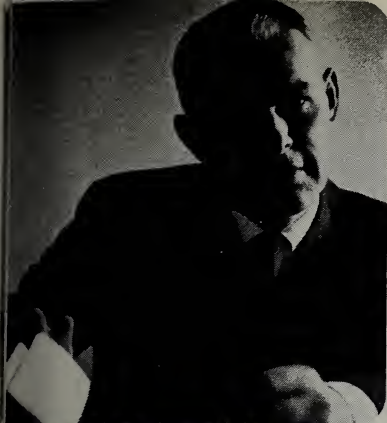
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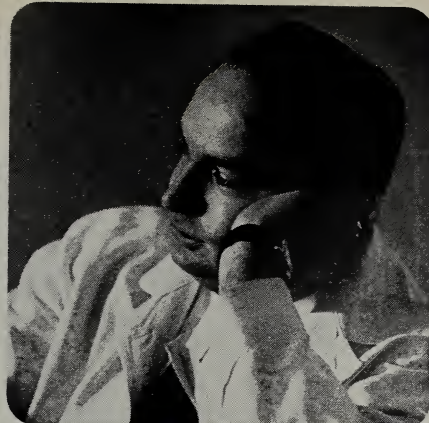
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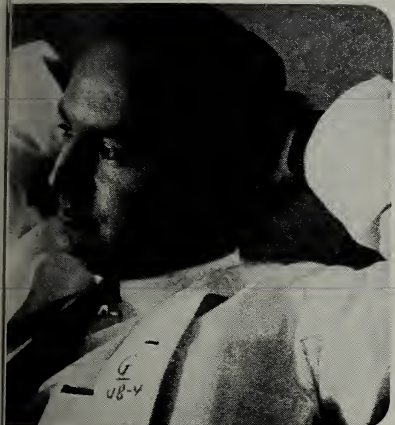
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hypertensive patients...



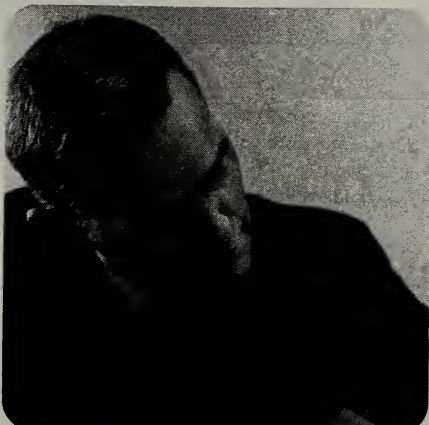
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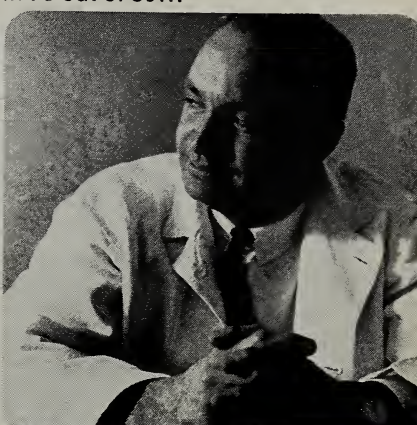
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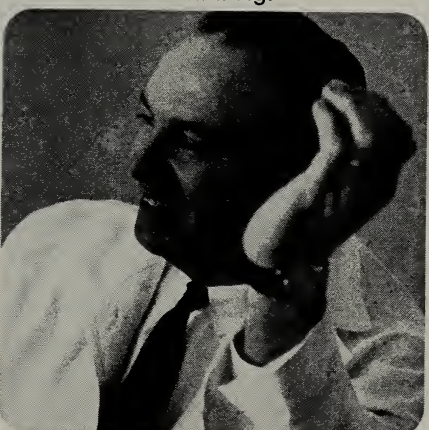
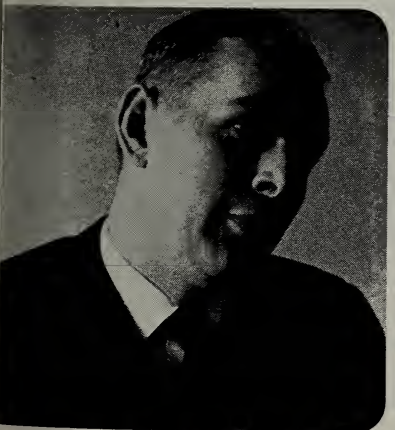
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\*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14-19, 1964.

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cessful fashion show and luncheon on March 16 at the Hotel Netherland's Pavillon Caprice, under the chairmanship of Mrs. James A. Schaal and her co-chairman, Mrs. Daniel C. Rivers. Apparel by Gidding-Jenny was modeled by Auxiliary members. Mrs. Leonard Visser presented the fashion commentary and music was provided by the Ted Raymore Ensemble. The luncheon was preceded by a social hour arranged by Mrs. Dale R. Wiethe, hospitality chairman. Mrs. Walter C. Timperman was in charge of reservations.

Doctors' wives of 25 nationalities were welcomed by the Hamilton Auxiliary on April 20 to a tea at the Taft Museum in their honor. Some 75 young women attended. Telephone numbers were exchanged and conversation flourished midst the babel of languages that ranged from those of South America to Iran to India to Greece — you take it from there! The Cincinnati group planned its first international gathering last spring and discovered how much the young guests of honor enjoy meeting each other.

Miss Katherine Hanna, curator, spoke on "Treasures of the Taft Museum Collection." Mrs. Joseph N. Wilson was program chairman, assisted by Mrs. Richard T. Wurzelbacher. Mrs. Edward Hartenian and Mrs. Harold Hiatt, hospitality co-chairmen, planned the dessert service.

The Hamilton Auxiliary group is also humming "Hello Money." Its December dance netted a profit of \$1,273.00 (for nursing scholarships); its Christmas card sale came up with a whopping \$2,125.00 (for AMA-ERF).

### A Nice Way of Doing It

Four Tuscarawas County members were presented with honorary life Auxiliary memberships at a luncheon in March given by the Auxiliary in their honor. They were Mrs. H. A. Coleman, Mrs. Charles J. Miller, Mrs. Burrell Russell and Mrs. Frank Yeager.

Mrs. Coleman was Tuscarawas' first president and instrumental in the Auxiliary's organization back in 1941. Mrs. Miller is a charter member, a past-president, and served four years as the state's Seventh District director. Mrs. Russell is also a charter member. Mrs. Yeager was secretary-treasurer in 1944-45. Mrs. Herbert F. Van Epps, state president-elect, presented the honorary life membership cards and ex-

## At Cincinnati Symposium



Dr. Karl Menninger (left), co-founder of the Menninger Institute, Topeka, Kansas, was guest speaker at a special state-wide symposium of the Cincinnati Society of Neurology and Psychiatry attended by neurologists and psychiatrists from all parts of Ohio. Conferring with Dr. Menninger at the Emerson A. North Hospital gathering are Dr. Glenn Weaver, Society President; and Dr. Howard Fabing, Cincinnati.

pressed the group's appreciation for the contributions made by these four outstanding members.

Twenty members attended the luncheon at the Reeves Motor Inn. Mrs. R. A. Wilson gave the invocation and Mrs. E. R. Hammersley, president, served as mistress of ceremonies. Arrangements of green and white carnations and shamrocks were used in the table appointments, and later were presented to the honored guests. Mrs. Hammersley announced that the Auxiliary will again co-sponsor (along with the District Nurses' Association) an appearance of Dr. Murray Banks on April 28 in the Dover High School Auditorium.

### Remember Those Dates!

May 12 - May 13 — The State Convention — Christopher Inn — Be seeing you there . . .

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**BUTLER**—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton. 4th Wednesday.

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**HAMILTON**—John J. Cranley, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

**WARREN**—O. Willard Hoffman, President, 20 E. Fourth St., Franklin; Ray E. Simendinger, 901 Broadway St., Lebanon.

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2670 Salem Ave.

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**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.

**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, 29 East Wood Street, Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Rorer St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Tuesday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—W. C. Clark, Jr., President, 223 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

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**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.

**HANCOCK**—Thomas W. Darnall, President, 1309 South Main Street, Findlay; Herbert L. Queen, Secretary, 327 Woodworth Drive, Findlay. 3rd Tuesday, monthly.

**HARDIN**—Clen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center. 2nd Tuesday, monthly, except June, July and August.

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**WYANDOT**—Franklin M. Smith, President, E. Saffle Ave., Box 68, Sycamore; Robert E. Goynne, Secretary, 432 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

### Fourth District

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**OTTAWA**—Robert Reeves, Port Clinton Road, Oak Harbor; Kenneth L. Akins, Secretary, 203 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.

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**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

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**GEAUGA**—Simon Onghesian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

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**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

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**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

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**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

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**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

## Eleventh District

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205 Elyria Block

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**ERIE**—Fred J. Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P.O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

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**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.

**MEDINA**—Richard C. Gosh, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Stanley L. Brody, President, 327 Park Ave. W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.



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## JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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# Classified Advertisements

Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Prices cover the cost of remailing answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

**FOR RENT:** Office suite, New Medical Bldg. Modern; on one floor; parking space; air conditioned. Call 442-0106 (Cleveland).

**G. P. WANTED** at once to take over established practice of 41 years; excellent small town in Toledo area; fine hospitals; attractive opportunity. Box 363, c/o Ohio State Medical Journal.

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**TWO GENERAL PRACTITIONERS** for Association consisting of General Practitioners and Specialists; new building with x-ray and laboratory; salary open; leads to partnership. Wyoming Medical Center, Cincinnati, Ohio 45215.

**GENERAL PRACTICE FOR SALE:** Modern office building with adjacent almost new 2-bedroom home in Bellefontaine. Open staff hospital. Leaving to specialize. Box 402, c/o Ohio State Medical Journal.

**COLUMBUS, OHIO:** Office space and/or medical practice available on east side. Three-year lease. Box 403, c/o Ohio State Medical Journal.

**GENERAL PRACTICE FOR SALE** near Columbus, Ohio, July, 1965. Modern Hospital with open staff. Attractive terms. Leaving to specialize. Box 404, c/o Ohio State Medical Journal.

**PSYCHIATRIC RESIDENCY AND STAFF POSITIONS** available — Appointments available at all levels for residency in three-year approved dynamic program in psychiatry. 2100-bed hospital with affiliated community service clinic, child psychiatry and psychosomatic medicine; individual and group psychotherapy under supervision of hospital staff and practicing psychiatrists in the community; organized didactic training in basic sciences, clinical neurology and psychiatry; hospital participates in visitors and exchange program; foreign graduates must be ECFMG certified; all Ohio Civil Service benefits including vacation, sick leave, retirement program; new pay scale effective January, 1965. Three years program: \$8,000-\$10,000 yearly; 5 years career program: \$11,000-\$16,000 yearly; those with 4 years private practice: \$12,000-\$14,000 annually. Staff psychiatrists wanted for positions paying from \$16,000 and up. Write: G. I. Podobnikar, M.D., Director, Education and Training, Columbus State Hospital, 1960 West Broad Street, Columbus, Ohio 43223.

**RURAL-SUBURBAN COMMUNITY** needs a General Physician. Will build a new Medical Center to doctor's specifications, with option to rent, lease, or buy. Within 10 miles from a new 96-bed hospital. Community of 2300 families in a growing area. New consolidated High School within 4 miles. Write Warsaw Lions Club, c/o Marvin Davis, Box 66, Warsaw, Ohio 43844. Phone 614-824-2421.

**GENERAL PRACTICE OFFICE FOR SALE.** Air conditioned, 5 rooms, carpeted, excellent location, large parking lot, records included; near 3 hospitals, close to excellent residential area; leaving to specialize in July. Phone 895-4541, Hamilton, Ohio.

**WANTED INTERNIST** to join well established 5-man group in town of 10,000 located in progressive area of 90,000; good pay, good living conditions. For particulars, contact Alex Shadid, M.D., Medical Director, Community Hospital-Clinic, Elk City, Oklahoma.

**PHYSICIAN** for large Eastern railroad; **ASSISTANT MEDICAL EXAMINER**; full time at Cincinnati, Ohio; vacation; work 8 hour day, 5 day week; fringe benefits. Box 416, c/o Ohio State Medical Journal.

**M. D. LICENSED IN OHIO** to join an expanding Emergency Room group. Opportunity offers regular hours with adequate time off, no overhead, excellent income on a fee-for-service basis and daily contact with medical specialists. A young, progressive suburban community with excellent schools, recreational facilities, churches close to the center of Cleveland. Contact A. C. O'Connor, Administrator, Parma Community General Hospital, Parma, Ohio.

**WANTED — GENERAL PRACTITIONER** to locate in our community of West Liberty, West Virginia, located 12 miles from Wheeling. West Liberty is the site of West Liberty State College and six miles from Bethany College; population of 600 plus surrounding territory. There are sites available for doctor's office. Write Mrs. Harold F. Daugherty, Box 62, West Liberty, West Virginia. Phone 336-7700.

**WANTED:** Physician to engage in general practice at Geneva-on-the-Lake, Ohio, summer resort and operate the emergency room service of Geneva Memorial Hospital from June 1 or July 1 to Sept. 8, 1965. Furnished home and office at Geneva-on-the-Lake. Rent free. No investment. Phone Geneva 466-3424 or write Dr. James A. Talbot, 681 E. Main St., Geneva, Ohio.

**EYE, EAR, NOSE AND THROAT PRACTICE:** Good opportunity for young E.E.N.T. specialist to take over 45 year old practice of the late Dr. A. R. Grierson. Excellent earning potential and future. For further information write to Mrs. A. R. Grierson, P. O. Box 872, Sandusky, Ohio.

**EAST PALESTINE, OHIO** much in need of general practitioner, man or woman; population 6,000 plus many surrounding villages and rural areas; good roads; promising location for physician's office. Phone GA 6-3358, Mrs. Myrtle A. Pelley Taylor, R.N., 208 W. Martin St., East Palestine, Ohio 44413.

**PORT CHARLOTTE, FLORIDA, NEEDS YOU.** Space available for a physician in three suite medical building complex with option for one-quarter interest in realty. For further information write J. F. Terry, 15908 Delaware Avenue, Cleveland, Ohio 44107.

**G. P. WANTED,** Aug. 1 to take over good practice. Excellent small town, DeGraff; near modern hospital in Bellefontaine. Attractive opportunity. Box 415, c/o Ohio State Medical Journal.

**FOR RENT:** Office of Cleveland G. P. deceased; fully equipped; 35 years established neighborhood practice; patients' records available. Box 398, c/o Ohio State Medical Journal.

**FOR SALE** to settle doctor's estate. Full length, top quality Autumn Haze \$4,000.00 Mink coat, size 14-16, recently purchased from prominent New York Furrier. Price \$2,800. Box 418, c/o Ohio State Medical Journal.

**PHYSICIAN WANTED.** Medical education director, full-time, salaried, Board certified or qualified, 350 bed general hospital. Please write, Administrator, St. John's Hospital, Cleveland, Ohio 44102.

**OB and GYN MAN** looking for association, group or clinic, or good location for private practice. Reply: Box 417, c/o Ohio State Medical Journal.

**WANTED: GENERAL PRACTITIONER.** Established practice near Toledo, Ohio, eight miles from hospital and university. Home, equipped office and financing available. Death reason for selling. L. R. McAdams, Ada, Ohio. Phone 634-3711.

**OFFICE FURNITURE FOR SALE:** Good condition. Columbus, telephone: 258-9956, Ext. 4.

**FOR SALE:** Picker X-Ray — Fluoroscope, Raytheon Microtherm and Beck-Lee Cardiac All EKG. Want to sell soon, as leaving to specialize. Michael Truman, M.D., 1070 Millville Ave., Hamilton, Ohio. Phone 895-4541.

**WANTED:** Qualified physician to join established practice of clinical problems in chest disorders and allergic respiratory problems — Bronchial Asthma, Emphysema, etc. Opportunity to work into clinical program and partnership-interest, as part of long-range remuneration from participation. C. H. Kalb, M.D., FCCP, FACA, 6030 W. Capitol Drive, Milwaukee, Wisconsin 53216.

**HELP! HELP! PHYSICIANS NEEDED.** One of Ohio's fastest growing and promising locations near new Dayton campus — (Extension "Ohio & Miami Universities"). Population to double by 1980. New addition to an already established building with a highly successful General Practitioner and Dentist. For information, write Don or Bob Morgan, 1711 E. 3rd Street, Dayton, Ohio. Better still, call collect. Area Code 513 — 254-3555. Evenings 513 — 426-0306.

(More Ads on Facing Page)



## Classified Advertisements (Contd.)

**ANESTHESIOLOGIST** wishes to practice full time Anesthesia in Ohio. Three years' approved complete training, Board eligible, several years of experience, good references. Ohio license. U. S. citizen. Box 419, c/o Ohio State Medical Journal.

**G. P. WANTED** to take over established practice beginning July 1, 1965. Would share office space with another General Practitioner. Modern office only three years old. Office located one block from 175 bed modern hospital. Contact Charles R. Blake, M. D., 1920 South Main St., Findlay, Ohio 45840.

**OHIO:** 12 years active general practice available in July. Beautiful suburban community of 5,000. One other physician; eight miles to good hospitals. New functional office, 1250 sq. feet. Nothing to buy unless equipment is desired. Rent \$150 monthly. Write or call collect. Miss Jo Denney, 322-1463 or 323-7651 c/o The Kissell Company, 30 Warder Street, Springfield, O.

### Former Ohioan Is Named Director Of Accreditation Commission

Dr. John D. Porterfield, III, well-known in Ohio where he was formerly director of the Ohio Department of Health and director of the Ohio Department of Mental Hygiene and Correction, has been named director of the Joint Commission on Accreditation of Hospitals.

The Joint Commission was established in 1952 by doctors and hospitals to constantly evaluate hospital care standards throughout the nation by voluntary methods of self discipline. For the past 10 years the commission has been directed by Dr. Kenneth B. Babcock whose resignation was announced in April, 1964.

Dr. Porterfield was director of the Ohio Department of Health, with offices in Columbus, from 1947 to 1954. In the latter year, he was named the first director of the Ohio Department of Mental Hygiene and Correction, when that agency was separated from the Department of Public Welfare.

Dr. Porterfield left Ohio to accept an appointment in Washington and was later made Deputy Surgeon General of the U. S. Public Health Service. Recently he has been coordinator for Medical and Health Sciences at the University of California in Berkeley.

A native of Chicago, Dr. Porterfield will have his offices there in the headquarters of the Joint Commission at 201 East Ohio Street. He belongs to the fifth generation of physicians in the Porterfield family.

**GENERAL PRACTICE FOR SALE OR RENT:** Office of deceased physician with full equipment, including x-ray, EKG, lab., instruments, etc. Excellent condition; community and surrounding area with population of approx. 5000. Will sell only equipment if interested. Dwight Pettay, Jr., 599 Dewey Ave., Cadiz, Ohio; phone 942-3100.

**FOR RENT WITH OPPORTUNITY TO BUY:** Office and equipment in Ashville, near Lockbourne Air Force Base; physician's office of long standing; nearby hospitals; convenient to metropolitan area. Box 420, c/o Ohio State Medical Journal.

**GENERAL PRACTICE:** For sale or possible association with general surgeon in Cleveland. Fully equipped including X-ray. Excellent opportunity. Present G. P. enters specialty training soon. Box 421, c/o Ohio State Medical Journal.

Dr. William Herman, Cleveland, participated in a panel discussion sponsored by the Cuyahoga County Association for Retarded Children.

Dr. Frank L. Meany, Cleveland, spoke before a group of the American Association of Retired People in Mentor.

The Southwestern Ohio Society of Family Physicians for the March meeting had as guest speaker Dr. Beverley T. Mead, professor and chairman of the Department of Psychiatry, Creighton University School of Medicine, Omaha, Nebraska. He discussed "Problems of Puberty."

Dr. Forrest E. Lowry was named Man of the Year by the Urbana Area Chamber of Commerce.

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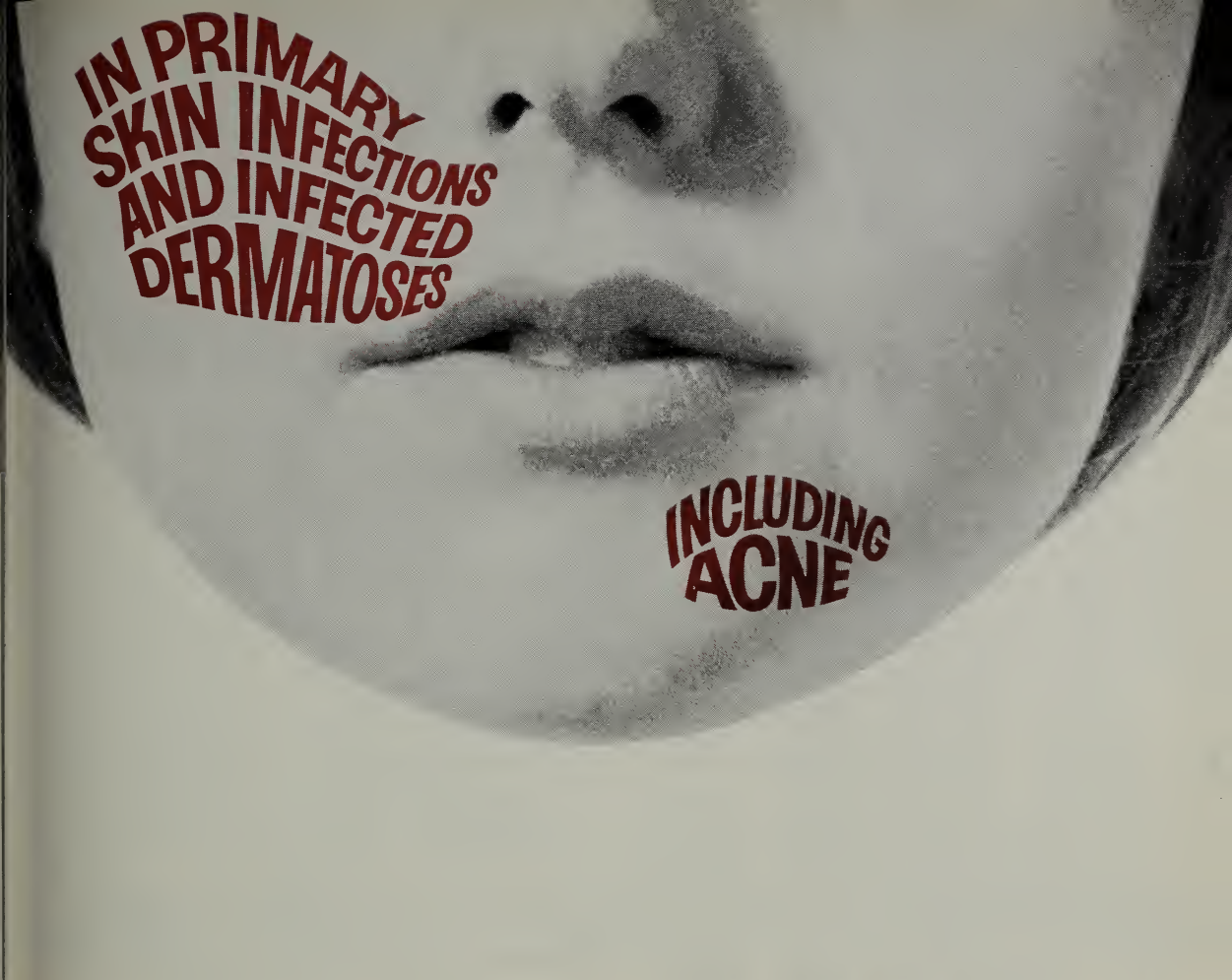
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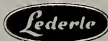
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## National Drug Reaction Reporting Program To Be Expanded

The U. S. medical profession, the pharmaceutical industry and the Food and Drug Administration (FDA), are cooperating to establish a major addition to existing adverse drug reaction reporting programs.

A Registry of Tissue Reactions to Drugs will be established within the Armed Forces Institute of Pathology (AFIP) in Washington. Joint sponsors are the American Medical Association, FDA and the Pharmaceutical Manufacturers Association. The AFIP has the world's largest repository of pathological material for research and education.

The purpose of the Registry will be to obtain autopsy or biopsy tissue specimens from suspected adverse drug reaction cases. The material will be thoroughly studied by all methods available to a full-time pathologist, including consultation with other authorities in pathology and toxicology. Results of the studies will be reported to local pathologists who furnished the study material, and monthly summary reports will be made to each of the three sponsoring organizations. The pathological material will remain on file at the Registry for future reference and study.

The tissue registry will augment the existing drug reaction reporting programs maintained by the AMA

and FDA. The FDA at present receives reports of suspected adverse drug reactions from about 500 cooperating federal and military hospitals, and from 110 civilian hospitals under contract. The AMA receives such reports from physicians in private practice, a number of hospitals not reporting to FDA, and other sources.

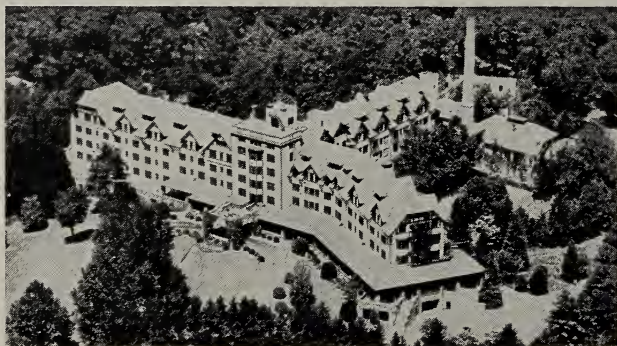
## Training in Psychosomatic Medicine for Non-Psychiatric Physicians

For general practitioners, or specialists in non-psychiatric fields, wishing to undertake a period of training in psychosomatic medicine as applied to their own practice and teaching, there are a limited number of six-month or one-year fellowships available on the psychosomatic and liaison service of the Cincinnati General Hospital. For fellowships available in January, 1966, and July, 1966, inquiries should be addressed to W. Donald Ross, M. D., Department of Psychiatry, Cincinnati General Hospital, Cincinnati, Ohio 45229.

Charles S. Wilson, New York City, management consultant, has joined the Cleveland Health Museum as director of development. In the new position, he will be concerned with the Museum's new building program and other phases of development.

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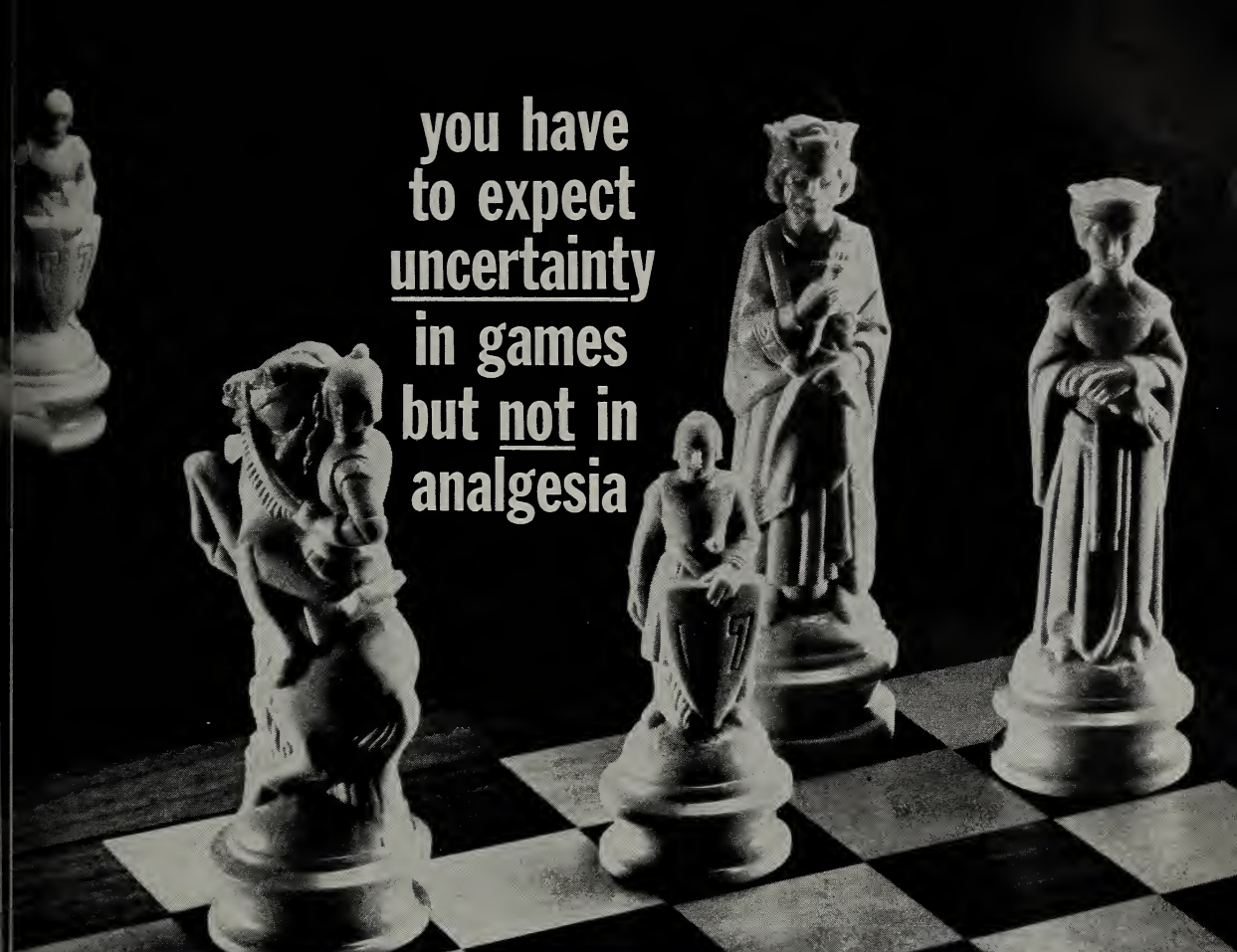
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# The Art of Käethe Kollwitz

RALPH I. FRIED, M. D.\*

GREAT ART has a twofold meaning for physicians. It is not only a thing of beauty to be viewed and admired but a revelation of how a sensitive human being reacts to some of the basic experiences of life—a matter which daily concerns each of us in the care of our patients.

The prime source for learning the truth about these feelings are the free expressions of human beings unrestrained by civilized veneers. The mores of primitive societies, the behavior patterns of little children, natural and induced dreams and the creations of genius provide a rich reservoir of study for the scientist interested in this subject. The basic truths of human behavior are expressed in the poetry of the Old and New Testaments and in Shakespeare. Great creative artists have been defined as individuals with strong inner drives and with the talent to transmute their id into the form of color design and composition. From the caves of Lascaux to the surrealism of de Chirico, beautiful pictures open the window to the soul of a sensitive human.

Such an artist was Käethe Kollwitz. She dwelt in a country that produced Goethe, Bethoven, Heine, and National Socialism. She was imbued with a sense of liberalism by her family and yet she existed in a society tinged with the tyrannies of a dying feudalism and a resurgent totalitarianism. Deeply sensitive, opposed to injustice and indignant of the hypocrisies of civilized life, she herself became the victim of the cruelest of tragedies perpetrated by the brutal forces rampant in her country.

She poured forth her feelings in her art. Poignant, somber, powerful, the drawings of Käethe Kollwitz are at the same time beautiful and revealing of human reaction to great events. We, as doctors, have a special affinity for her work since her husband was a physician and the influence of his work and his patients is mirrored in her art. Pediatricians find an even closer bond of interest, not only because many of her drawings are of direct pediatric interest but because Käethe Kollwitz in her lifetime, espoused many liberal, humanitarian and idealistic causes identified with human welfare that have been part of the warp and woof of pediatrics.

## Influences of the Formative Years

Käethe Kollwitz was born in Königsberg, Germany, in 1867. Her grandfather had formed a

progressive religious group known as the Free Congregation. Her father who had been a mason became pastor of this congregation. These two people were undoubtedly responsible for inculcating her with the liberal principles that were to guide her life.

Her girlhood was a happy and sunny time. She records in her diary that even at this young age she was attracted to the sights and sounds of the working class quarter of Königsberg. Much later when she was called a socialist artist, she states, "My real motive for choosing my subjects almost exclusively from the life of the workers was that only such subjects give me in a simple and unqualified way what I felt to be beautiful. Bourgeois life as a whole seemed pedantic."

She became engaged to Karl Kollwitz, a medical student, at age 17 but her father persuaded her to study art in Munich for one year. In 1891 Dr. Kollwitz received an appointment to a tailor's Krankenkasse, so he and Käethe were married and moved into 25 Weissenburger Strasse, Berlin N. 58 which was to be their home until destroyed by the bombing of World War II.

## Berlin and World War I

In two short years she began to receive artistic recognition. The social aspect of her work became more and more apparent. She gained insight into the miseries of the workers because this was the milieu in which she lived. She was greatly influenced by classical music and the classic writing of such authors as Zola, Gorky, Dostoevsky, Tolstoy



FIG. 1. "Visit to the Children's Hospital"

\*Dr. Fried, Cleveland, is a member of the Pediatric Staffs, Mt. Sinai Hospital and St. Luke's Hospital.

Submitted September 7, 1964.





FIG. 2. "Sick Child"

and others. Her initial great work was "The Cycle of the Weavers" which was based on the doomed revolt of the Silesian Weavers. This work was proposed for a gold medal but this was interdicted by Kaiser Wilhelm II. This small disappointment was only a harbinger of sorrows to come. Her life was replete with tragedy, her art was dark and somber, reflecting the bitter events of her life.

She was at first bewildered by the advent of World War I, never having experienced the events of war. She was swept out of her initial melancholy by the enthusiasms of the young Germans, including her beloved son Peter. The death of Peter in Flanders was a crushing blow and in 1918 when Richard Demel called for the best men to volunteer for a last resistance she publicly opposed his position in an essay, "Seed for planting must not be ground" (Goethe). This was followed by many posters and drawings depicting the effect of war on children: *Vienna is Dying, Save its Children!* — 1920; *Germany's Children Starving*, — 1924; *Bread*, — 1924; *Never Again War*, — 1924.

In 1919 Käthe Kollwitz was elected to the Prussian Academy and was given the title of Professor. She became interested in sculpture as a medium and during this period she created the beautiful and moving "The Parents" as a memorial to the fallen

Peter. This was dedicated in the Military Cemetery at Roggevelde, near Dixmuiden. Many drawings, lithographs and etchings were created during these years, many on subjects with a direct medical interest. A partial list includes: "At the Doctors (Schwangerschaft)"; "Run Over"; "Playing Forbidden"; "Mother and Sick Child"; "Parents with Sick Child"; "Alcohol"; "Hand of Death"; "Waiting Room at the Children's Doctor."

#### Artistic Triumph and Personal Despair

When the Nazis assumed power in 1933, she was predictably stripped of her title and prerogatives



FIG. 3. "Waiting Room at the Children's Doctor"



FIG. 4. "Run Over"

and her art was banned and classed as "degenerate." Only her prestige and her friends saved her from internment in a concentration camp. She gave much of her time in these years to provide a sympathetic audience for her fellow Germans who were the victims of man's inhumanity.

In 1940 Dr. Kollwitz died and the life energies of Käthe Kollwitz were noticeably diminished from this event on to the end. The pace of the tragedy quickens, her oldest grandson, Peter, was killed on the Russian Front in 1942. After this she virtually stopped working. In 1943 the bombing of Berlin became intolerable and she moved to the house of Margaret Boenning, a sculptress, near Nordhausen. No. 25 Weissenburger Strasse was consumed in the holocaust of the siege of Berlin and many valuable works of art were lost. In 1944 it was imperative that she move once again, this time to Moritzburg near Dresden. She was under the protection of Ernest Heinrich, Prince of Saxony. On April 22, 1945, a few days before the Armistice, the weary, gentle, people's artist reached her final rest.

The beautiful drawings of Käthe Kollwitz represent to us the dignity of the relationship of parents to their children, the compassion we feel for parents and children when ugly events engulf their welfare, the nobility of the physician in his help and understanding to those who have need to be dependent upon him and finally the revelation, in a graphic form, of the deepest feelings of human beings to the great events of life.

## A Helpful Classification Of Epistaxis

A working classification of epistaxis which might be helpful, particularly in a general hospital, can be outlined as follows:

- I. Spontaneous epistaxis —
  - a. Hypertensive — which is usually posterior
  - b. Infective — which may be anywhere but which is usually anterior — particularly in young children
- II. Traumatic epistaxis
- III. Epistaxis where underlying specific organic disease is suspected — such as tumors, blood dyscrasias, etc.

It is suggested that most cases of spontaneous epistaxis are not primarily a problem for the otolaryngologist; that perhaps they belong as readily to the internist or the general practitioner. Perhaps he could manage this problem and the patient more satisfactorily simply because he knows his patient better. — R. W. Hanckel, M. D., and Richard Carter, M. D., Charleston, S. C.: *Southern Medical Journal*, 57:282-286, March 1964.

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\*Dorhout Mees, E. J., and Geyskes, G. G.: *Acta med. Scandinav.* 175:703, 1964.

**Photos:** A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.



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\* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).

AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

# Health Officers of Cincinnati, Ohio And the Problems of Their Day

KENNETH I. E. MACLEOD, M.D., M.P.H.\*

## PART I

THE inimitable Dr. Daniel Drake of Cincinnati, as quoted in the Second Volume of Warden's Statistical, Political and Historical Account of the United States of America, published in 1819, stated:

... that the diseases of this state [Ohio] are common in the same latitudes east of the Alleghany Mountains, but that some are less violent and frequent; that pulmonary consumption, which, in some of the towns of the Atlantic states, destroys from a fourth to a sixth of the persons who die annually, in the town of Cincinnati does not occasion one twentieth of the deaths. In the winter season there are cases of pleurisy and peripneumonia, which, often united with bilious infections, become of difficult cure without the aid of mercury. The croup [most probably includes diphtheria] often prevails, and carries off yearly a number of children . . .<sup>1</sup>

### Health an Early Concern

It is clear, from this statement, that a developing concern with health and conditions leading to ill health was evident early in our city. It was Winston Churchill who said, as some others also have said, that to know the present and anticipate the future, one has to examine even more closely the past. This review, therefore, of the history of the former health officers of Cincinnati and the problems they faced in their day, may be of some interest not only to health workers but also to the general reader.

The first Board of Health, according to the city documents, was formed in 1826. It consisted of three members. The minutes of City Council dated February 22, 1826, reads as follows:

BOARD OF HEALTH: On motion resolved that John Sherlock, Lewis Howell and Calvin Fletcher be and they are hereby appointed and constituted a board of health of the city under the ordinance passed this day. The Council appointed Josiah Whitman, M.D., examining physician, agreeably to said ordinance . . .

It might therefore be inferred from the foregoing minute that *de facto* Dr. Whitman was Cincinnati's

first public health officer, but further research of these early minutes of City Council adds some other and confusing items. Thus on May 4, 1824, we find that two persons were to be appointed as health officers (presumably and probably health "inspectors") "each to receive for this service \$2 per week." Also, and in spite of the action taken on February 22, 1826, on April 19, 1826, we find the following minute:

HEALTH OFFICERS: Agreeably to a resolution on the minutes of last week; The Council now proceeded to elect a Health Officer and an Additional Health Officer; and on counting the ballots it was found that Frederick Facom was duly elected Health Officer; and Jesse Churchill was duly elected an Additional Health Officer for the ensuing year (at the pleasure of the Council) . . .

### Daniel Drake Elected

But we find yet further action pertinent to the establishment of a Board of Health in the minutes, dated May 12, 1826, as follows:

BOARD OF HEALTH: On the ordinance offered, entitled an ordinance to establish a Board of Health for the City of Cincinnati, and to prevent the introduction and spreading of the smallpox therein, on motion . . . was adopted. Septimus Hazen, Henry Gassaway and William Noble among the members of Council; John P. Foote, Calvin Fletcher from the citizens; were appointed a Board of Health; in pursuance of the ordinance passed this day . . .

But this is by no means the final action as to the early establishment of a board of health, for again, and on June 6, 1827, we find the following minute:

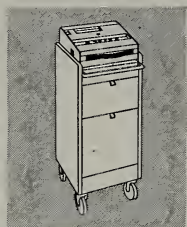
BOARD OF HEALTH ELECTED: On motion of Mr. Storer; The Council went into the election of a board of health to serve under the late ordinance on that subject and on counting they were found as follows for Ebenezer H. Pearson, 10 votes (viz . . . names of those voting listed); for Daniel Drake, 12 votes . . .; for Josiah Whitman, 14 votes . . .; for Vincent C. Marshall, 13 votes . . .; for William Stephenson, 8 votes . . .; for Ezekial Hall, 9 votes . . .; for Moses Lyon, 12 votes . . .; for Nathaniel Wright, 9 votes . . .; which said nine members were declared to be duly elected. Ordered that the City Clerk be directed to notify the persons elected to serve as a

\*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

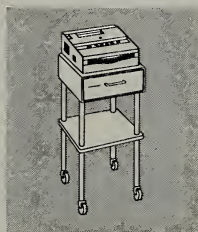
Submitted October 4, 1964.



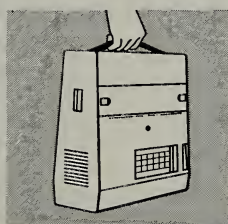
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Cincinnati, Ohio 45236

Board of Health of their appointment, and that he furnish Dr. E. H. Pearson, one of the said Board with a copy of the ordinance prescribing the duties of said Board . . ."

At least three of the foregoing members are physicians — Dr. Pearson, Dr. Drake and Dr. Whitman — and of course Drake is the same Daniel Drake of current and posthumous fame. There were to be many further revisions of the Board of Health ordinance, as for example on December 17, 1828, which will serve as the example.

### Accident Prevention

As to concern of City Council and these various early boards of health with public health problems, we are given no doubt as to what matters were considered of concern — smallpox, nuisances, markets, hogs. Thus, on September 18, 1824, we find Council putting out an order to have removed from the city a person with smallpox "to a safe and convenient place." As we perambulate our way through the maze of these early minutes, which incidentally are beautifully written from the point of view of penmanship, (they could write clearly in these days) we find many items of interest, but too lengthy to discuss in the text of this paper. An abbreviated list is appended in the final chapter.

On accident prevention it is interesting to note that City Council put out orders "to prevent bathing in the Miami Canal in the City," (June 4, 1828) and again on July 2 of the same year "to prohibit bathing in the Ohio River." On June 4, 1828, and even more interestingly, an order was put out "to prevent accidents from the discharge of cannons . . ."

### Disease Prevention

The Council's concern with safe water is indicated by several early minutes. Thus, on October 19, 1825, we find an ordinance passed "to regulate public wells."

The control of nuisances and the stemming of vicious pestilences were the two primary concerns of these boards of health, and helpless indeed were these boards in the face of most of the epidemics with which perforce they had to contend. Yet, in one instance, they had a tool to combat the disease — namely in the case of smallpox. The following resolution indicates generally the action which often was taken:

*Minutes of City Council of April 29, 1826:*

RESOLVED that the Trustees of Several Wards be, and they are hereby authorized to take such measures in their wards, to have vaccinated persons in their wards, with powers to draw on the Treasury for funds to defray necessary expenses . . .

As to some of the nuisances regarding which these boards received many citizen complaints, one can visualize some amusing scenes, as on occasion perhaps, swarms of hogs charged up or down the city's thoroughfares, and herds of cattle or single animals vied with the citizen for a share of the pavements.

There was sure to be upset to human dignity, frequently tearful or laughter-arousing.

The chatter of the barnyard was ever present, and that wholesome aroma so characteristic of that situation everywhere on the nostrils. But our forefathers had stalwart olfactory systems, which some of us today might envy as we inhale in great quantities in our cities, the air-polluting excrement of smokestacks and automobile exhausts.

The board of health was given power to establish and maintain quarantine, to order the reporting of certain communicable diseases (1832), and vaccination against smallpox was made necessary for admission to the city's schools as early as 1845.

### Health Department Established, 1867

We can date the establishment of a formal health department, to carry out the policies and orders of the Board of Health from the year 1867. The staff, in addition to the Health Officer, Dr. William Clendenin, consisted of a clerk, two meat and milk inspectors, one sanitary policeman, and 13 district physicians. Provision for this kind of organization was through an ordinance of City Council creating yet another Board of Health, with a membership of five individuals, with the mayor, Mr. Charles F. Wilstach acting as its President, ex officio. This ordinance is dated, March 29, 1867.

In his annual message, Mayor Wilstach noted that "the General Assembly of the State has taken a step in the right direction, in promptly passing a strong health bill, by which the Board of Health will be enabled to enforce the most wholesome and vigorous measures . . ."

### Dr. William Clendenin: 1867-1873\*

In making his own first annual report to the Mayor, Dr. Clendenin noted a total of 5,994 deaths in the year ending February 28, 1867 — 2,033 having died from Asiatic cholera and 454 from consumption. He gave the following items as causes of sickness in the city:

- (1) The mode of constructing dwelling-houses . . . Building houses upon made and undrained ground . . .
- (2) Damp and badly ventilated cellars; and using cellars for keeping chickens, geese, dogs, calves, etc. . . .
- (3) Imperfect light and ventilation of houses . . .
- (4) Badly constructed and arranged house-drains . . .
- (5) Privy-vaults . . .
- (6) Impure water . . .
- (7) Well and cistern water . . . contaminated by drainage from privy-vaults . . .
- (8) Shade trees, when too thick; brick walls, fences, closed courts . . . all causes of disease by stagnating the air and excluding sunlight.
- (9) Overcrowding of tenement houses . . .

*(To Be Continued in July Issue)*

### Reference

1. Cockburn, T. Aidan: The Health of Ohio in 1819. *Ohio Med. J.*, 59:480-481 (May) 1963.

\*There is no clear record of the role of Dr. Marmaduke Barr Wright in the Health Department's records, but an historical review of the contributions made to medicine by certain earlier physicians (compiled by Dr. Cecil Striker) notes that he was connected with the Board of Health during the years 1861-1865 and mention of his name appears several times in the city documents, particularly in connection with work at the City Infirmary.





# Scientific Section

VOL. 61

JUNE, 1965

No. 6

## Hospitalization of the Mentally Ill

### Analysis of Questionnaire Concerning Knowledge of Ohio Hospitalization Laws Applying to Mental Patients

VICTOR M. VICTOROFF, M.D., and SAMUEL J. MANTEL, JR., Ph.D.

LATE in 1960, an Ad Hoc Committee for Revision of Commitment Laws of Ohio was appointed by the Academy of Medicine of Cleveland to collaborate with Mr. David Matia, Representative from Cuyahoga County, to review the laws affecting hospitalization of the mentally ill. In collaboration with Judge Harold Ewing of the Ohio Association of Probate Court Judges, and with legal experts from the Ohio Division of Mental Hygiene, this Committee drafted a major revision of the Ohio Commitment laws.<sup>1</sup>

This law was passed and became a part of the statutes in October, 1961. After the law had been in force for about a year, the Committee devised a questionnaire to determine how the provisions were actually working in the field. (See Appendix A.) Ohio's physicians were invited to describe their experience and their views about psychiatric patients encountered in daily practice. With the cooperation of the Ohio State Medical Association, the questionnaire was distributed to all members of the Ohio State Medical Association, and the returns collected by the Committee.

The revision of the old law was based on the premise that psychiatric illness is a prominent problem in every physician's practice. He must be ready to recognize mental illness and personally guide the patient to prompt and adequate treatment. The new statutes are designed to make it easier for any physician to aid his patient with or without the help of a consulting psychiatrist.

Submitted November 24, 1964.

#### *The Authors*

● Dr. Victoroff, Cleveland, is a member of the OSMA Committee on Mental Health; chairman, Ad Hoc Committee for Mental Health Legislation, Cleveland Academy of Medicine; President, visiting staff of Windsor Hospital, Chagrin Falls; member, active staff, Doctor's Hospital, and associate staff, Huron Road Hospital, Cleveland.

● Dr. Mantel, Cleveland, is Associate Professor of Economics, and Director, Economics-in-Action Program, Case Institute of Technology.

The authors of this paper, together with Mr. Jack Stones of the Computer Center of the Case Institute of Technology, financed by a grant from the Cleveland Foundation, analyzed all the responses from the questionnaires. The data collected are summarized in Table 1.

Two of the questions asked on the questionnaire were: "In a year, how many patients do you see who need institutional psychiatric care?" "Of these, how many actually are admitted?" The number of patients admitted was then computed as a per cent of the total requiring admittance. This ratio was used as a criterion of success. (See Items 6 and 7, Table 1.)

#### **Knowledge of Law Important**

The new law was passed to simplify the commitment process while protecting the patient from en-

croachments on his civil rights. If it is an effective law, some relationship might be expected between a doctor's knowledge of the law and his ability to get prompt institutional care for those patients he felt needed such care. It is evident that the more a physician knows about the commitment law, the more apt he is to get hospital care for his mentally ill patients. Those doctors who claimed "thorough" understanding of Ohio's 1961 Hospitalization Law for the Mentally Ill were able to admit a significantly higher proportion of the patients they felt required hospitalization than doctors with less knowledge of the law.\*

With one major and one minor exception, knowledge of the new commitment law did not appear to be related to medical specialty area. Eighty-nine per cent of the responding psychiatrists professed a "thorough" or "general" knowledge of the law; and, as a group, these psychiatrists are able to secure beds for about 90 per cent of the patients they wish to hospitalize. The other exceptional group is general practitioners. Almost 20 per cent of the GPs claimed a good understanding of the law. Between 90 and 95 per cent of the reporting physicians in all other specialty areas had little or no knowledge of the law.

No specialty group, with the possible exception of Obstetrics and Gynecology, had a record of admission success that approached the psychiatrists.

It seemed reasonable to suppose that psychiatrists and highly trained physicians, practicing medicine in urban areas, would have a better admission rate than those not so highly trained and practicing in rural areas. It was assumed that the former would probably know more about the law and, operating in the neighborhood of a better medical communication system, could be expected to have a higher level of admission success. But this expectation proved to be mistaken. Physicians in highly populated urban centers have no better record of getting institutional care for their patients than those living in the hinterlands. Statistical tests of the data in Table 3 established that such differences as exist in the "Admission per cent" between counties of varying populations are not significant.

Nor is knowledge of the law at a higher level in the more heavily urbanized areas. If one aggregates the 73 Ohio counties with less than 100,000 population, 19 per cent of the reporting physicians (including psychiatrists) claim a "thorough" or "general" knowledge of the law. In the 15 remaining counties, which have populations greater than 100,000, 20 per cent of the doctors claim a good knowledge of the law. If psychiatrists are not included in these totals, the respective percentages are approximately halved. While knowledge of the law is evenly spread across urban and rural areas, the level of knowledge

TABLE 1. Results from a Questionnaire on the Ohio Commitment Law for Mentally Ill (HB 529)

Item Number 1. Responses by specialty

Specialty	No. of Responses	% of Possible Responses
Allergy .....	3	8
Anesthesiology .....	10	2
Aviation Medicine .....	0	0
Cardiovascular diseases .....	1	1
Dermatology .....	7	5
Gastroenterology .....	0	0
General Practice .....	289	9
Internal Medicine .....	134	10
Neurological Surgery .....	2	3
Neurology .....	0	0
Obstetrics and Gynecology .....	42	6
Occupational Medicine .....	6	5
Ophthalmology .....	11	4
Orthopedic Surgery .....	24	11
Otology-Laryngology-Rhinology .....	14	7
Pathology .....	3	1
Pediatrics .....	21	4
Physical Med. and Rehabilitation .....	1	4
Preventive Medicine .....	0	0
Psychiatry .....	61	14
Public Health .....	1	2
Pulmonary diseases .....	5	9
Radiology .....	8	3
Surgery .....	72	6
Thoracic Surgery .....	2	4
Urology .....	10	6
Administration .....	0	0
Plastic Surgery .....	2	7
Total Responses .....	729	Average Response 7.5%

Item Number 2. Response by population range of respondent's county

Size of County	No. of Responses	% of Physicians in county responding
2,000 - 24,999 .....	10	6.7
25,000 - 49,999 .....	81	9.4
50,000 - 99,999 .....	109	8.5
100,000 - 199,999 .....	61	9.5
200,000 - 299,999 .....	24	6.9
300,000 - 499,999 .....	94	6.0
500,000 - 699,999 .....	141	5.5
700,000 - 899,999 .....	62	3.6
900,000 and over .....	147	4.4

Item Number 3. Respondent familiarity with the new Commitment Law

(Physicians, excluding psychiatrists)

Degree of familiarity	No. of Responses	% of Respondees
Thoroughly .....	14	2.1
Generally .....	75	11.2
Superficially .....	70	10.5
Slightly .....	104	15.6
No .....	399	59.7
No answer .....	6	.9

(Psychiatrists only)

Degree of familiarity	No. of Responses	% of Respondees
Thoroughly .....	19	31.1
Generally .....	35	57.4
Superficially .....	2	3.3
Slightly .....	4	6.6
No .....	1	1.6

Item Number 4. Is there any change in your experience with handling psychiatric problems since the new Law was passed in October, 1961?

Degree of Change	No. of Responses	% of Responses
No Change .....	423	58.0
Easier .....	130	17.8
More Difficult .....	9	1.2
No Answer .....	125	17.1
No Experience .....	42	5.8

Item Number 5. Have you made use of the provision which allows informal confidential investigation by a psychiatric aide to the court?

	No. of Responses	% of Respondees
Yes .....	39	5.3
No .....	643	88.2
No Answer .....	47	6.4

(Continued on Next Page)

\*A statistical test (Chi-square) was applied to determine the probability that the specific results shown in Table 2 might occur by chance alone. The odds are more than 100 to 1 against the notion that the relationships in Table 2 are purely accidental.



(Table 1 Continued)

Items Number 6 and 7. *In a year, how many patients do you see who need institutional psychiatric care? Of these, how many are actually admitted?*

	Require Admission	Are Admitted	Admissions as %
Physicians, less psychiatrists....	3,664	2,252	61.5
Psychiatrists .....	2,778	2,436	87.5
All Physicians .....	6,442	4,688	72.7

Item Number 8. *Do you need a provision which permits two doctors to hospitalize a patient without going through court procedure?*

	No. of Responses	% of Respondees
Yes .....	267	36.6
No .....	266	36.6
No Answer .....	110	15.1
Doubtful .....	82	11.2
Now in Effect .....	4	.5

Item Number 9. *How do you handle an acute psychiatric case?*

Method(s)	No. of Responses	(Note: multiple responses allowed)
Refer to psychiatrist .....	522	
Refer to state receiving hosp. ....	205	
Accept responsibility for management of the case .....	107	
Refer to private psychiatric hosp. ....	88	
Refer to general hosp. ....	73	
Refer to clinic .....	39	
Withdraw from case .....	35	
Call the police .....	27	
No answer .....	81	

Item Number 10. *Do you believe there is a problem (awkward, serious or critical) in your practice in handling the following psychiatric patients?*

Type of patient	Nonspsychiatrists	% Frequency of Mention
Chronic alcoholics .....	48.5	
Agitated senile .....	40.9	
Suicidal .....	39.4	
Marital problems .....	38.0	
Acute alcoholics .....	37.4	
Acute depressed .....	32.8	
Postpartum psychosis .....	31.3	
Violent psychotic .....	30.7	
Drug addicts .....	30.2	
Delinquent adolescents .....	26.8	
Mentally defective .....	25.4	
Medically and surgically ill psychotics .....	13.8	
Epileptics .....	10.3	

Type of patient	Psychiatrists	% Frequency of Mention
Postpartum psychosis .....	63.9	
Chronic alcoholics .....	59.0	
Drug addicts .....	47.5	
Acute alcoholics .....	41.9	
Agitated senile .....	41.9	
Mentally defective .....	36.1	
Suicidal .....	34.4	
Marital problems .....	34.4	
Violent psychotic .....	29.5	
Delinquent adolescents .....	24.6	
Acute depressed .....	23.0	
Medically and surgically ill psychotics .....	18.0	
Epileptics .....	18.0	

TABLE 2. *Admission Success, by Degree of Familiarity with the Law.*

Familiarity with Law	Patients seen Requiring Admission	Patients Admitted	Admissions per cent
Thoroughly .....	1291	1223	94%
Generally .....	1958	1485	75%
Superficially .....	456	294	64%
Slightly .....	777	484	62%
No .....	1964	1209	61%
No Answer .....	12	6	50%

is so low that one must look with considerable doubt at the whole mechanism of communication in the medical profession.

### Informal Methods Sometimes Work

Nonetheless, thousands of patients are currently receiving treatment in hospitals and were being admitted long before the new law was passed. We are all familiar with the time honored tactics, sometimes extra-legal, that have been utilized to care for both routine and hard-core problems in medical-psychiatric practice. One questionnaire, received too late

TABLE 3. *Admission Success, by County Population Range.*

County Population	Number of Counties in Range	Patients seen requiring admission	Patients Admitted	Admissions per cent
2,000 - 24,999	16	87	51	59%
25,000 - 49,999	33	680	472	69%
50,000 - 99,999	24	911	591	64%
100,000 - 199,999	5	595	418	70%
200,000 - 299,999	2	89	65	73%
300,000 - 499,999	3	645	459	71%
500,000 - 699,999	3	1815	1396	76%
700,000 - 899,999	1	488	388	79%
900,000 and over	1	1148	861	75%

for inclusion in the main body of statistics, illustrates the point neatly.

This doctor is a general practitioner from down-state Ohio. There are no psychiatrists listed in his county. He is more than 50 miles from the nearest state hospital. He sees five or six patients each year who need institutional care. He claims no knowledge of the new commitment law, but he obviously has developed a workable set of procedures to get help for his mentally ill patients, for he reports that all of them are actually admitted. He explains, "In severe cases that will not respond quickly, I usually am able to get cooperation from a Probate Court Judge and get very quick admission to Receiving Hospital."

But for every doctor with a set of operative and workable informal methods for admitting patients, there are dozens not so favored. There were the 14 reporting otolaryngologists who were able to gain admission for only 11 of the 109 patients they saw who needed hospitalization. On the one hand there were two pediatricians (of 21 reporting) who profess a good knowledge of the new law. They claimed to be able to get hospital care for 100 per cent of those children who needed it. Compare that record with the less than one-out-of-three admission rate for the 13 pediatricians who claimed no knowledge of the commitment law.

Historically operative, informal methods for getting mentally ill patients cared for can be effective, but most physicians simply have not developed or do not have access to these methods.

It has been difficult to mobilize public, political and professional sympathy and support for the

acutely ill mental patient. The crucial reason why is summarized in a significant paragraph from "Action For Mental Health," the final report of the Joint Commission on Mental Illness and Health:

One reason the public does not react desirably is that the mentally ill lack appeal. They eventually become a nuisance. People do seem to feel sorry for them; but in the balance, they do not feel as sorry as they do relieved to have out of the way persons whose behaviour disturbs and offends them.<sup>2</sup>

Psychiatric emergencies are seldom inherently dramatic. The problem of helping Aunt Matilda, age 73, who is found mumbling and incoherent in her bedroom, or of dealing with the young mother who has locked herself in the bathroom with her 12 day old infant, is not good newspaper copy. Yet, these episodes are medical emergencies and require immediate intervention just as urgently as the auto ac-

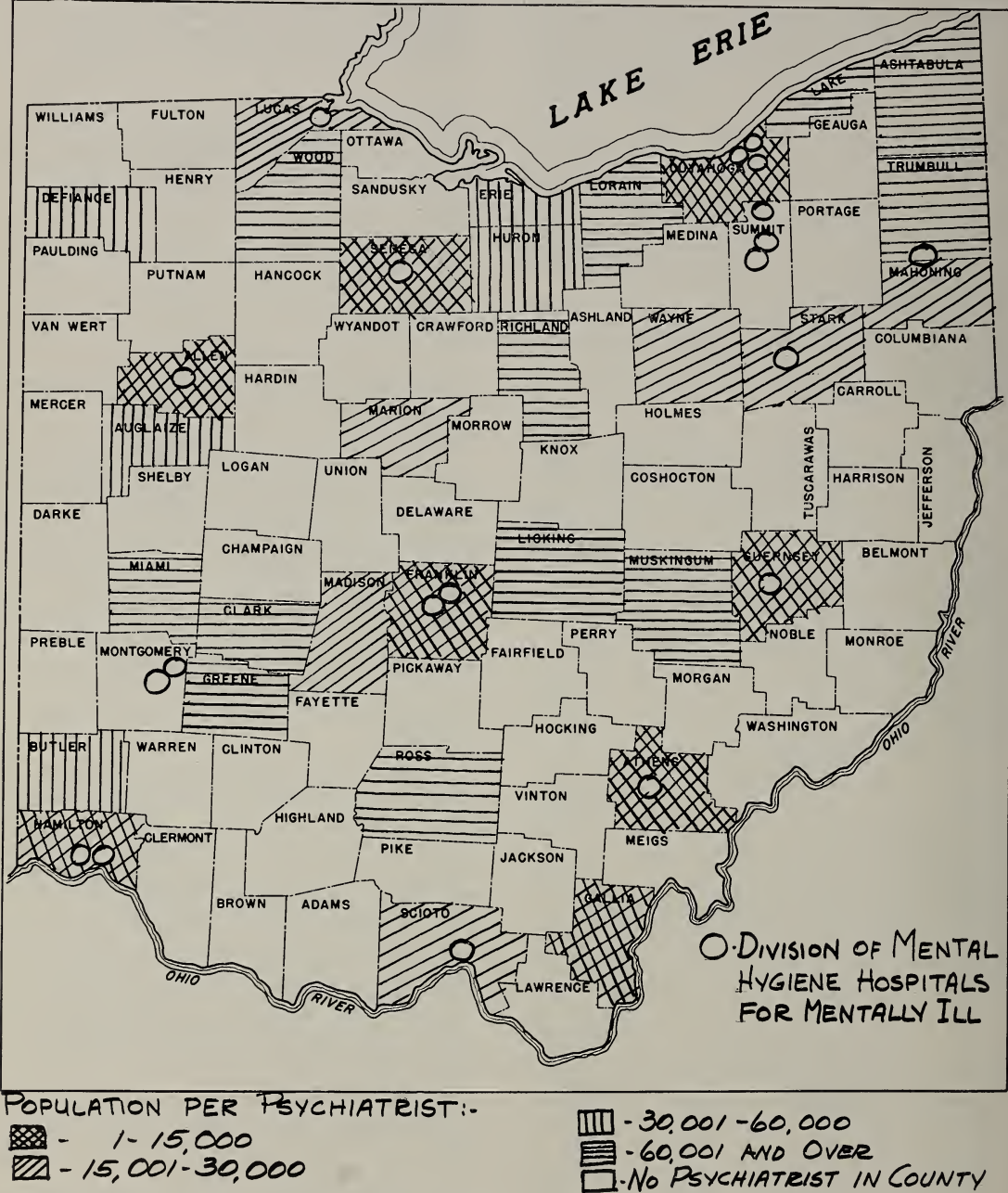


FIGURE 1



cident casualty with a torn femoral artery requires tourniquet and transfusion.

### Nonpsychiatrists See Most Mentally Ill

Physicians prefer to pass the responsibility for these problems to the psychiatrists, but this survey indicates that psychiatrists see far less than half (43 per cent) of the acutely mentally ill patients. A look at the map illustrating the density of psychiatrists in Ohio makes it clear that several million Ohioans have little possibility of ready referral to a private psychiatrist. (See Fig. 1.) On the positive side is the fact that Ohio's Division of Mental Hygiene, with 20 psychiatric hospitals and five institutions for the mentally retarded are, generally, strategically distributed around the State. Given reasonable support, the Division of Mental Hygiene could serve adequately the 30,000 patients assigned to their care by law and custom.

But psychiatric patients are seen by all doctors, everywhere in the State. There is evident dissatisfaction among the respondent physicians as to the adequacy of the care these patients receive.

The physicians of Ohio testify that in their experience, 30 per cent of all patients who need institutional care for mental illness in this State do not get it. When confronted with a psychiatric emergency, 85 per cent of physicians (less psychiatrists) either try to find a psychiatrist or seek to admit their patient into a psychiatric hospital. Nonpsychiatrists see almost 6 out of 10 (57 per cent) of all patients who urgently require treatment for mental illness, and place about one half (48 per cent) of the total who enter a hospital.

### Some Doctors Criticize Psychiatrists

Some doctors were well satisfied with the cooperation they received from psychiatrists, state hospitals, the Probate Courts, and approved of new mental health clinics in their areas and the psychiatric units in general hospitals. They expressed acceptance of the new law, and praised and encouraged the Committee for its work. But a number were rancorous against psychiatrists who were criticized as "too Freudian," "unavailable," "refuse house calls," "too busy." They were dismayed at the lack of hospitals or clinics for the care of emergency psychiatric problems; they voiced fears that the new law might imperil the civil rights of the patient. In this regard, some doctors indicated they had more trust in the judgment of the courts than fellow physicians. The respondents asked for information about the new law, and many felt education was definitely needed for doctors, lawyers, judges, police and the public.

Thoughtful suggestions were offered: Some urged the creation of a medical board with quasi-legal, plenary powers to monitor and administer in cases requiring psychiatric care involving abridgment of civil liberties. Others suggested a law which would permit

long-term hospitalization on a voluntary basis for alcoholics and drug addicts. Local community mental health resources, half-way houses, more adequate pay for professional personnel in state service, and effective use of psychologists and family counselors were advocated.

A small, but sometimes vehement, number of physicians disclaimed interest or responsibility for the psychiatric patient. Among these was the expressed fear of lawsuit and reprisal for involvement with psychiatric patients. As one doctor pungently put it, "Regardless of law, unless I am completely protected from legal action by a patient or his relatives, I shall continue to refuse any responsibility and continue to leave the patient and his family to his own sources of help."

### Many Criticize Ohio System

The doctors expressed their opinion, sometimes colorfully, that treatment of the mentally ill in Ohio is strait-jacketed by a poorly financed, inadequately staffed system for state hospitals and clinics which operate without continuity of leadership or informed support by the public, doomed to mediocrity by the indifference of state governmental officials. One physician wrote: "Ohio's psychiatric and general mental health program stinks . . ."

The doctors condemned the administrative officers and their staff members for refusal to accept flagrant emergencies.

"My last patient," one respondent claimed, "was not examined even after he had been there (in a State hospital) for a week. I, as a family physician, am not allowed to see them or to follow their progress, except during regular public visiting hours . . ."

Especially vehement was the expression of bitterness about the nine to five banker's hours allegedly enjoyed by the staff at the state hospitals with no services at all evenings or weekends. They felt helpless at the lack of facilities for handling one of the most serious problems, the agitated senile patient. Some physicians bluntly accused their state and local medical associations of indifference and lethargy to the whole area of mental health needs.

### Patient Civil Rights a Problem

Again and again in their responses and comments, the question of civil rights was reiterated. It is apparent from the above results that doctors are of a mixed mind concerning this issue. To the question, "Do you need a provision which permits two doctors to hospitalize a patient without going through court procedure?"—they split their "yes" and "no" answers exactly 50 - 50. (See Item 8, Table 1.) A massive 88 per cent of the responding M.D.s stated they had not made use of the provision in the law which allows informal confidential investigation by a psychiatric aide to the Court, of patients potentially dangerous to the community. (See Item 5, Table 1.) The statute empowers the investigator, if necessary,

to initiate hospitalization proceedings. The fact that only one county, Cuyahoga, had such an aide when the survey was taken does not nullify the impression that even if there were such a person appointed by the Court, the doctors might not make use of him, mirroring strong concern for the patient's civil liberties and privacy.

"I am decidedly against that provision of the law under which a person can be sent to a state hospital without Court commitment involuntarily. This is doing away with the 'due process' of law and endangers our whole American system."

Particularly vigorous were the doctors who took the trouble to emphasize that the treatment of drug addicts is presently punitive, cruel, and unscientific. They want something done about it.

It became increasingly plain that many problems which arise for the physician exist because of misconceptions concerning the laws, and misinformation about available facilities in the State for the care of the mentally ill. Ignorance about the law and its content is implied in the statements which follow:

"Commitment by two physicians would help the alcoholics and drug group." The law provides for this, defining alcoholics and drug addicts as "mentally ill individuals." (Sec. 5122.01 (A) of the Ohio Revised Code.)<sup>3</sup>

"It seems in some cases too easy for one of a couple to have the other placed in a state hospital." (In cases of marital discord.) The law explicitly protects against "spite" commitments in provisions requiring reasonably prompt psychiatric examination, review of the case periodically by the Head of the hospital, reports to the Court at required intervals as well as the provision for hearings and other sections protecting the patient's right to communicate with his attorney and his physician. The employment of a psychiatric investigator attached to the Court, as provided for in Sec. 5122.13, will grant even greater protection against mischievous use of the hospitalization laws by false affidavit.

"On emergency admission, I feel that one physician's examination should be adequate instead of having to locate two physicians, especially late at night." Section 5122.08 (B) of the Revised Code exactly includes such a provision.

A physician who fears that homicidal patients cannot be detained until they attack someone, suggests, "I believe chiefs of police or some responsible public officer should have power to pick up these people . . . and commit them to an institution . . ."

The code makes it possible for a law enforcement officer to take a dangerous individual into custody, convey him to an appropriate mental institution, and secure his admission, (Sec. 5122.10). Safeguards in the law sharply limit the possibility of

exploitation of this proviso to the detriment of the patient's citizen's rights.

### The Most "Serious" Problems

Neither the character nor the severity of the problems faced by physicians was related to the location of the physician. Every area in the State held essentially the same complex of mentally ill patients as every other area. Nor did either specialty or location play any role in determining how the doctor dealt with these patients. The physicians described the relative difficulties they experienced in caring for patients suffering from various psychiatric illnesses. (See Item 10, Table 1.) The tabulation lists the syndromes in order of the difficulty met by psychiatrists and nonpsychiatrists in caring for them.

Four of the ten responding anesthesiologists said that "delinquent adolescents" were a "serious" problem in their practices. More than half of the general practitioners said that "awkward," "serious," or "critical" problems were posed by the following psychiatric patients: acute alcoholics, chronic alcoholics, suicidal, agitated senile, violent psychotics, delinquent adolescents, and marital problems. Internists reported similar difficulties. A majority of the specialists in obstetrics and gynecology noted serious problems in dealing with marital problems, postpartum psychoses, acute depression, and suicidal patients.

More than half the reporting orthopedic surgeons had serious difficulty dealing with agitated senile, suicidal, and both acute and chronic alcoholics. Indeed, every major specialty area except public health and cardiovascular diseases reported critical problems in handling mentally ill patients. We cannot surmise a reason why only one of approximately 100 specialists in cardiovascular diseases answered the questionnaire. He apparently saw no acute psychiatric patients since he saw no patients, who, in his opinion, required institutional care.

The data were searched for evidence of bias against the psychiatrist, supposedly held by many physicians. There was, inevitably, the doctor who said:

My own opinion about psychiatrists in Ohio and elsewhere, is there are . . . too damn many who know too little.

My present experience with psychiatrists (with credentials) is that when they get hold of a patient they keep on with their "interviews" till the patient runs out of money or dies or decides perhaps that he (the patient) is acting like a jackass and sometimes improves a little.

Some people are really mentally unbalanced and permanently, but so long as we adhere to the Freudian Thesis of sex and considering grownups as children and children as grownups, there will continue to be many individuals who will continue to be nuts.

Despite the commentary above, this view is probably in the minority. In the questionnaire, physicians were asked how they handled an acute psychiatric case. More than 40 per cent of the respondents listed "refer to a psychiatrist" as their only response to this question. (See Item 9, Table 1.) If the responses of all doctors who indicated that they



would refer the case to a psychiatrist or psychiatric hospital are totaled, then any notion of resistance to or bias against consultation or referral to psychiatrists is untenable. Such responses represent 85 per cent of all answers.

### Some Evidence of Anti-Psychiatric Bias

Yet, a review of our data indicates that an important minority group among physicians still dissociates itself from responsibility and even awareness of psychiatric patients. This may fairly be inferred from the following comment which was boldly scrawled across the questionnaire returned by a very active obstetrician, "I never see patients of this kind." But more serious evidence of this dissociation is deduced from the fact that no responses were submitted from Ohio's nine physicians specializing in aviation medicine, 49 neurologists, and 32 doctors practicing in the field of preventive medicine. It is difficult to understand how Ohio's 54 hospital administrators could fail to note problems with the mentally ill in their hospitals.

We are dubious in accepting the 1 per cent response from specialists in cardiovascular disease as an indication these specialists do not see cardiac neurosis. We hesitate to infer that 69 of 70 physicians in public health who failed to send in a return do not meet or do not recognize organic psychotic reactions secondary to epidemic infectious disease, nor are ever troubled by paranoid and delusional persons complaining about the water supply, or fall-out from nuclear testing.

### Statistical Validity

The failure of certain medical specialty groups to respond to the questionnaire not only raises questions about their awareness and recognition of psychiatric problems, but also raises questions concerning the quality of the statistical evidence upon which our conclusions are based. The problem of validating a study such as this one is not particularly difficult if the characteristics of the population universe are known and if the sample is carefully drawn to conform to those characteristics. Unfortunately, in this research, the sample was not pre-structured to reflect the population accurately, but resulted more or less by chance.

Questionnaires were mailed to all of the 9,679 paid-up members of the Ohio State Medical Association. From this mailing, 729 replies were received. Since the sample was not controlled, it contained an unknown bias.

Obviously, if a sample is badly biased, the information developed from it will have little value. To get some insight into both the degree and direction of the bias, the sample was tested in two ways. First, the data were tested for internal consistency. Second, wherever possible, the conclusions were tested to find out how often the results generated by our sample might have occurred merely by chance.

As the size of the group being polled gets larger,

it is normal to find that the level of response tends to center around some specific per cent. In this case the total response was 7.5 per cent of the universe. When our sample was broken down by population groups, it exhibited a marked tendency to center around a 7 to 8 per cent response. When the returns were segmented by medical specialty areas, the same tendency was noted. We arranged the answers to almost every question by the size of the population group from which they were drawn and by medical specialty, and the consistency of response was seen repeatedly. This is merely to say that when we drew sub-samples from our 729 responses, they had much the same characteristics as the parent sample. This is not proof that we had a representative set of returns, but such internal consistency is rarely seen in unrepresentative samples.

Since our returns seemed to be internally consistent, they were tested for bias. Perhaps the simplest way to describe the bias we found is to say that doctors who were more interested in, and alert to psychiatric problems tended to respond to the questionnaire in greater numbers than those who were less interested. If, for example, the number of patients admitted to institutional care by our respondents is extrapolated to the entire medical population of the State, the actual rate of admission would be almost twice as large as it is. Strangely enough, this means that our conclusions are conservatively biased.

It is reasonable to suppose that those physicians with a relatively high interest in psychiatric problems would be more apt to be familiar with the commitment law. Thus, the estimate that about 10 per cent of the nonpsychiatrists have a general or thorough knowledge of the law is, if anything, on the high side. Similarly, the doctors who did not respond to the questionnaire very likely have a lower level of success in getting their psychiatric patients hospitalized than those who did respond. On the other hand, the bias casts some doubt on our conclusion that there is little prejudice against psychiatry in the medical profession.

Finally, we asked ourselves this question: If, in fact, half the doctors in the State were reasonably familiar with the commitment law, how likely is it that we would have gotten the results we did get merely by chance? The answer is that our results would have occurred only once in several billion trials. To put it another way, there are only three chances out of a thousand that our "10 per cent" figure concerning familiarity with the law is in error by more than plus or minus 3 per cent.

As far as we can determine, the information developed from this questionnaire appears to be valid and reliable.

### Conclusion and Summary

Ohio's laws pertaining to mental hygiene are probably among the most progressive in the United

States. However, if they are not utilized, the laws represent so much dead verbiage. By a process of slow seepage, advantages of the new statutes have become evident in medicolegal experience over the past three years. Voluntary admissions are increasing, and the number of Court-committed patients is decreasing.

Dr. F. A. Lingl<sup>4</sup> compared hospital admissions at Columbus State Hospital in 1960 and in 1962. His statistics do indicate a sharp increase in total number of admissions but a decided increase in the number of voluntary and nonobjected, nonjudicial placements.

#### Classification of Hospital Admissions in 1960 and 1962

	Total Admissions	Court Placements*	Voluntaries	Other Nonjudicial
1960	1,154	1,090	59	5
1962	1,590	790	406	394

\*Including emergency admissions in which judicial procedures were initiated immediately after admission.<sup>4</sup>

Acutely ill patients are being moved more promptly into both public and private hospitals, and veteran's hospitals. There is freer use of mental health clinics to which the Court may now refer patients. Better cooperation and coordination of effort and responsibility are reported in certain areas across the State among the professions in medicine and law, and the law-enforcement agencies. The "spite" commitment problem is becoming a rarity.

Yet, the benefits made possible by the new codes lag far behind, because universal understanding of the statutes is far from achieved by those who should be most familiar with them, namely the physicians, to whom responsibility for the care of the mentally ill must fall. We emphasize that prompt diagnosis and definite action to care for acutely ill mental patients falls to the lot of the nonpsychiatrist in over 50 per cent of such cases. This assignment will probably increase as population gains run ahead faster than we can turn out psychiatrists, and as familiarity with psychiatric syndromes continues to spread throughout the medical profession. Our survey indicates that some physicians, particularly among specialties, have a blind spot, and do not recognize mental illness when they see it, or prefer to look the other way, eschewing responsibility for the psychiatric patient.

There is a limit to what you can expect even the best of laws to do. They cannot teach common sense, nor a basic knowledge of medicine or law. No matter how smoothly the legal instrument operates to admit patients into psychiatric hospitals, it cannot guarantee that once there, the patients will get adequate professional care.

The Committee on Mental Health Legislation of the Academy of Medicine of Cleveland has been busy in preparation of an explanatory brochure, which, reinforced by seminars in every hospital and clinic

should make it possible to familiarize the members of the Ohio State Medical Association with the specific remedies available by statute for first aid for the psychiatric patient.

The physicians in Ohio, on request for candid expression of opinion via a questionnaire were obviously dissatisfied with critical unmet needs in our State for care of the mentally ill. They revealed crucial problems with inexperience in certain psychiatric cases such as acute and chronic alcoholics, senile psychosis, marital conflicts and puerperal psychosis. Their general ignorance of the laws which affect hospitalization and other issues raised by their responses, create a mandate for the State medical authorities to improve greatly the quality of medical teaching about psychiatry to physicians.

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We must make special note of our appreciation for the generous cooperation received from the Ohio State Medical Association who printed and distributed the questionnaire at the expense of the Association, and placed accurate statistical data at our disposal concerning physician-population in Ohio.

We acknowledge the substantial assistance offered by the American Medical Association in offering the breakdown by specialty of Ohio's physicians, saving us much tedious research.

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#### Appendix A

##### Questionnaire re Ohio Commitment Law For Mentally Ill (HB 529)

Ohio has had a new Commitment Law for the Mentally Ill since October, 1961. The Ad Hoc Committee for Mental Health Legislation of the Cleveland Academy of Medicine is now preparing proposed corrections and amendments to the new



law for the next session of the Ohio Legislature. We earnestly solicit suggestions from all physicians in Ohio concerning their day-by-day experience with the Law.

- 1. Specialty, if any .....
- 2. City, town or county where practicing .....  
Kind of practice: *solo, partnership, group, institutional, other* .....
- 3. Are you familiar with the new Commitment Law? (*Thoroughly, generally, superficially, slightly, no.*)
- 4. Is there any change in your experience with handling psychiatric problems since the new Law was passed in October, 1961? (*No change, easier, more difficult.*)
- 5. Have you made use of the provision which allows informal confidential investigation by a psychiatric aide to the court? .....
- 6. In a year, how many patients do you see who need institutional psychiatric care? .....
- 7. Of these, how many actually are admitted? .....
- 8. Do you need a provision which permits two doctors to hospitalize a patient without going through court procedure? .....

9. How do you handle an acute psychiatric case? (Withdraw from the case; refer to psychiatrist, clinic, general hospital, private psychiatric hospital, State receiving hospital; call police; accept responsibility for management of the case; other; .....)

10. Do you believe there is a problem in your practice in handling the following psychiatric patients: (*Designate proper descriptive word in spaces provided: No, Awkward, Serious, Critical*)

- Acute alcoholics . . . . . (.....)
- Chronic alcoholics . . . . . (.....)
- Drug addicts . . . . . (.....)
- Acute depressed . . . . . (.....)
- Suicidal . . . . . (.....)
- Agitated Senile . . . . . (.....)
- Mentally defective . . . . . (.....)
- Violent psychotic . . . . . (.....)
- Medically or surgically ill psychotics . . . . . (.....)
- Delinquent adolescents . . . . . (.....)
- Postpartum psychoses . . . . . (.....)
- Epileptics . . . . . (.....)
- Marital problems . . . . . (.....)
- Other: .....

11. Remarks, criticism, suggestions:

SUICIDE, when it occurs, is the outcome of a disease process which has prevailed for a considerable period of time previously. The factors which bring it about are essentially two. First, there is a drive to destructiveness, which Freud saw as the manifestation of a death instinct or a set of death instincts. Second, there is a set of mechanisms that normally function to increase by several orders of magnitude the flexibility and plasticity of instinctual behavior but which, when they miscarry under the influence of disease, serve to reflect destructive instincts away from the external objects and back upon the self.

These mechanisms operate unconsciously, but they achieve representation in conscious or preconscious thought by creating fantasies. The fantasies seem to explain or justify the suicide and also to make it more attractive or, at least, less frightening.

Of course, the mechanisms which lead to suicide constitute in each case a portion of the repertoire of instinctual mechanisms of each individual. Since it is this same repertoire which determines the form of the antecedent illness, we can expect to find a relation between the psychodynamics of this illness and the mechanisms and fantasies of suicide which evolve.

When these mechanisms and fantasies appear in the course of an illness, we must alert ourselves to the possibility of suicide. And when they disappear, we may infer that the danger of suicide has receded. — Sidney S. Furst, M. D., and Mortimer Ostow, M. D., New York, N. Y.: *Bulletin of the New York Academy of Medicine*, 41:190-204, February 1965.

# Topical 5-Iodo-2'-Deoxyuridine In Dimethylsulfoxide (DMSO)

## A New Treatment for Severe Herpes Simplex

LEON GOLDMAN, M. D., and KARL W. KITZMILLER, M. D.

TOPICAL THERAPY with 5-iodo-2'-deoxyuridine has been used effectively in herpetic keratitis. The good results of this antiviral chemotherapeutic agent in herpes simplex infection of the eye, however, has not been established clearly by well controlled studies in herpes simplex infections of the skin, such as the series of Burnett and Katz.<sup>1</sup> Some difficulties of topical antiviral chemotherapy in these circumstances are the selection of the time period when the agent is used, the frequency of application, the actual penetration of the agent, and the natural course of the infection in the patient. Therefore, the patient with frequent large and severe recurrences of established intensity and duration should be used for these types of experiments.

In topical therapy the role of the vehicle is important. Dimethylsulfoxide is an excellent vehicle, although, unfortunately, most of the information and speculation regarding this has been in the public press. The therapeutic uses in a variety of diseases have been reported by Jacobs, Bischel and Herschler.<sup>2</sup> Well controlled studies on the effect of the enhancement of percutaneous absorption *in vivo* of hexopyrroonium bromide, fluocinolone acetonide and *in vitro* of C<sup>14</sup> hexopyrroonium chloride and C<sup>14</sup> hydrocortisone by dimethylsulfoxide (DMSO) have been reported by Stoughton and Fritsch. Its significant reactions as regards topical use have been those of skin irritation, dryness and urtication, especially in high concentrations, and a garlic-like odor to the breath. As yet, little is known of its acute toxicity on absorption from topical application over large areas of the body and, as yet, in man nothing is known of its chronic visceral toxicity. In our clinical studies of the topical use of DMSO as a vehicle, the reactions of dimethylsulfoxide (DMSO) itself have been only those of local reactions and the offensive odor.

Into a vehicle of 90 per cent dimethylsulfoxide and 10 per cent distilled water, we incorporated

### The Authors

● Dr. Goldman, Cincinnati, is Professor and Chairman, Department of Dermatology, University of Cincinnati Medical Center; Director of Laser Laboratories, University of Cincinnati Medical Center and Children's Hospital Research Foundation.

● Dr. Kitzmiller, Cincinnati, is Clinician, Dermatology Clinics, Cincinnati General Hospital; Instructor of Dermatology, University of Cincinnati College of Medicine.

5-iodo-2'-deoxyuridine as a 1 per cent solution. The resultant mixture was clear. The freshly prepared solution was used for topical application. Two per cent has also been used.

To attempt a control study, patients with recurrent and severe herpes simplex infections were selected rather than those with occasional small herpes simplex infections of the lip. These patients were all treated early in the course of their infection. Patients with severe lesions of more than two days' duration were not included in this series, although this medication was used to acquire data on reactions to the topical therapy.

### Report of Cases

The severe cases included nodular edematous lesions involving the entire right eyebrow in two patients. These lesions were associated with severe preauricular adenopathy and, in one patient, posterior cervical adenopathy on the right side. One patient had recurrent cellulitis of the entire left cheek associated with herpes simplex of the lower eyelid, and two patients had recurrent gluteal herpes simplex infections, one with continued relapses for five years and one patient with severe hemorrhagic types. In addition to these five patients, two patients with extensive recurrent herpetic simplex lesions of the lip were also treated. Diagnosis was established by the history, clinical appearance, and, in four of the patients, by cytological smears stained for the giant multinucleated epidermal cells.

The crude controls in this small selected series of

From the Department of Dermatology of the College of Medicine, University of Cincinnati. Dimethylsulfoxide (DMSO) furnished by Dr. Victor Gubersky, Associate Medical Director, Syntex Research, Syntex Corporation, Palo Alto, California. 5-Fluorouracil supplied by Dr. Edward Miller, Department of Clinical Investigation, Hoffmann-LaRoche, Inc., Nutley, New Jersey.

Submitted December 31, 1964. Study done in part by Public Health Service Research Grant No. RH-00024 from the Division of Radiological Health.



patients were the history of previous episodes with duration and the intensity of the local reaction known. Five of the seven patients had topical therapy instituted less than 24 hours after the onset of the lesions. In two patients, the therapy was begun less than 12 hours after onset. The patient with the hemorrhagic gluteal herpes simplex infection was started within 48 hours. The medication was applied sparingly four times a day. The patients were warned about burning and dryness of the skin. Ninety per cent was selected as the initial concentration to attempt to provide maximum absorption of the 5-iodo-2'-deoxyuridine since 100 per cent DMSO uniformly produces irritation. In our investigative studies with topical dimethylsulfoxide, applications to the face were more frequently associated with burning and direct irritation than similar concentrations used elsewhere on the skin.

In the patient treated within 12 hours after the beginning of redness associated with the recurrent herpes simplex of the eyebrow, no lesions developed in the skin except slight redness and scaling. However, the severe preauricular adenopathy and also the postauricular adenopathy on the right side in this patient persisted for four days although no skin lesions developed. This was the first time in a long sequence of recurrences that this patient had had her skin eruption aborted.

In the other patient with the lesion of the eyebrow, this area was already edematous. This lesion subsided promptly in 48 hours. There was also marked improvement in the preauricular lymphadenopathy. A persistent scaling was present for a week afterwards without any tenderness or discomfort. No dermatitis was present from the topical application of the 5-iodo-2'-deoxyuridine in dimethylsulfoxide.

The patient with the severe recurrent gluteal herpes simplex had prompt relief of her pain and discomfort, including relief of pain in the inguinal area on that side. The patient claimed that she had not had such relief of her recurrent herpes simplex during its entire previous course. Topical 5-iodo-2'-deoxyuridine is being continued in the same concentration in this patient now to attempt to prevent recurrences since her recurrences are so frequent. After three weeks of application once a day, there have been no recurrences. This is the longest period that the patient has gone without one of her frequent recurrences. There has been no dermatitis, as yet, from the DMSO.

The patient with the hemorrhagic gluteal herpes simplex had subsidence of the lesions in 48 hours with some redness persisting. In the other patients the lesions subsided in 48 hours with dryness and scaling.

#### Comment

In this small series there was significant improvement in all patients with only slight irritation of the skin from this topical application even though, in

five patients, the DMSO was used about the face. In a series of patients with molluscum contagiosum, 5-iodo-2'-deoxyuridine is also being used in control studies. One control used in the series of herpes simplex was the restriction of the use to early and severe and large lesions. Another type of control attempted was the use of DMSO itself. Topical 80 per cent and 90 per cent dimethylsulfoxide has been used in four patients with mild herpes simplex of the lips, without any significant results save dryness and burning of the lips. It is important to note that in the well controlled series of Burnett and Katz, the median cure time was seven to nine days. No patient cleared in less than four days. In three patients with herpes zoster and in a series of patients with warts, no effects were observed in the patients with herpes zoster save for some relief of pain. As yet, the studies in warts, even with occlusive bandages, show no definite results with the DMSO alone.

With the local use of antimetabolites as antiviral therapeutic agents in DMSO in small areas there is little danger of systemic absorption and interference with DNA synthesis in cells. Cytogenetic studies have been done with nuclear cytology of adjacent skin cells and karyotype studies from peripheral blood cultures. This may not hold with topical use over large areas of the body when systemic toxicity may develop. The dryness of the skin noted in these patients could be from the DMSO itself rather than the interference with cellular metabolism of the epithelial cells by the 5-iodo-2'-deoxyuridine. Other topical antiviral chemotherapeutic agents in DMSO, which we are investigating, are 5-fluorouracil and N methyl isatin beta thiosemicarbazone.

#### Summary

Seven patients with recurrent severe large herpes simplex lesions early in their course were selected as trial subjects for a study of the effects of the topical application of 1 per cent 5-iodo-2'-deoxyuridine in 90 per cent dimethylsulfoxide (DMSO). Controls used were the previous episodes of these infections and the use of the dimethylsulfoxide (DMSO) itself. Significant clinical improvement was obtained by early and repeated topical therapy of this antiviral chemotherapeutic agent in this new and effective vehicle.

Reaction to the therapy in this small and selected series included only irritation of the skin. Additional studies of antiviral chemotherapeutic agents in dimethylsulfoxide (DMSO) are warranted.

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# Solitary Eosinophilic Granuloma Of Bone

## Report of Two Cases Occurring in Unusual Locations

CHESTER S. LOWENDORF, M. D.

TWO cases of solitary eosinophilic granuloma of bone are reported because of their unusual locations. In the first case the lesion crossed an epiphyseal line. The other case involved the apophysis of the os calcis.

Sbarbaro and Francis<sup>1</sup> state that eosinophilic granuloma was not encountered by them in the bones of the hands or feet. No attempt will be made here to consider the relationship of multiple lesions of eosinophilic granuloma of bone with Schüller-Christian disease or Letterer-Siwe disease. It is felt that the reporting of solitary lesions in unusual locations is in itself worthwhile.

### Case Reports

Case No. 1. A 3½ year old boy complained of pain, for three weeks, in the right lower extremity. He exhibited a limp for about the same time, and cried out with pain at night. Past history revealed the occurrence of mumps one week prior to the onset of the limb pain.

*Physical Examination* of the abdomen was negative, with no palpable masses. He had pain on pressure over the lower end of the right femur. There was some limitation of complete flexion of the right knee. There were no enlarged inguinal lymph nodes.

*Laboratory Findings* were as follows: Hemoglobin was 13.3 Gm. per 100 ml., hematocrit was 38 per cent, leukocytes were 10,400 per cu. mm. with 4 stab forms, 63 neutrophils, 2 eosinophils and 28 lymphocytes. Sedimentation rate was 18 mm. in one hour. Bleeding time was 1 minute, while coagulation time was 3 minutes, 45 seconds. A patch test for tuberculosis was negative and a purified protein derivative test was negative in the second strength. Urine examination was negative for albumin and sugar. A serum VDRL (Venereal Disease Research Laboratory) test was negative.

X-rays revealed a very unusual cystic lesion about 16 by 23 mm., extending across the distal epiphyseal line of the right femur (Fig. 1). It appeared to involve equally the epiphysis and the metaphysis. X-rays of both the skull and chest were negative.

In the differential diagnosis the following were considered: tuberculosis, a Brodie's abscess, a neurogenic tumor, an hemangioma, a chondroblastoma, fibrous dysplasia, an eosinophilic granuloma and a bone cyst.

*Operation:* A longitudinal incision was made just lateral to the semimembranosus and medial head of the gastrocnemius in the popliteal area. A lymph node found in the soft tissue was removed. The periosteum was stripped from the femur for a short distance and a needle inserted into the bone so that x-ray examination would reveal the exact pathologic area with respect to the needle. A window was then opened in the midline of the femur. Upon breaking through the cortex, a watery, gray material exuded,

### The Author

● Dr. Lowendorf, Youngstown, is a member of the Attending Staff in Orthopedic Surgery, St. Elizabeth Hospital.

followed by thick, hemorrhagic material, resembling thrombus and pus.

With a curet, grayish white tissue, suggestive of granulation tissue was then removed. When the wound was washed out with saline, it was noted that the epiphyseal line had been crossed. A portion of the specimen was submitted for bacteriologic culture. The wound was then closed.

*Pathologist's Report:* Frozen section suggested a benign lesion, probably granuloma. Bacteriologic culture revealed no growth in 48 hours. Later, the gross specimen consisted of soft, gray-yellow tissue. Microscopic examination showed young fibrocapillary tissue infiltrated with small round cells. Most of these round cells appeared to be eosinophilic leukocytes which in some areas were so dense as to form an abscess. Between the eosinophils were large numbers of histiocytes, most of which contained considerable quantities of lipid material. Also present were numerous giant cells of osteoclastic variety, containing 20 to 30 regular nuclei. There were also occasional, partially eroded bone trabeculae present with foci of necrosis, some collections of lymphocytes and scattered pleomorphic myeloid elements. Sections of the lymph node revealed normal architecture although markedly distorted by numerous histiocytes and giant cells within the sinusoids. There were also large numbers of eosinophilic granulocytes. The diagnosis was eosinophilic granuloma of bone and lymph node.

*Postoperative Course:* The patient did very well. Four months after surgery, an x-ray showed filling in of the operative defect. A year later he had full range of motion of his knee. Three years after surgery, he was free from symptoms. There was no shortening in the right lower limb. X-rays taken at that time continued to show filling in of the defect and no deformity of the femur.

Case No. 2. A 12 year old boy gave a history of having jumped off a garage roof three weeks before admission to hospital. His right heel did not hurt immediately. Three days later, however, he began to have pain in his right heel. *Physical Examination:* He apparently had severe pain about the right heel with point tenderness over the insertion of the right tendoachillis. The right foot was held in marked equinus. There was no swelling or redness present over the right heel but there was slight ecchymotic discoloration of the skin. He would not allow the foot to be brought up to a right angle and would not actively dorsiflex his right foot.

*X-ray Examinations:* These were negative both immediately after the injury as well as after admission to the hospital. *Laboratory Findings:* Urine examination and

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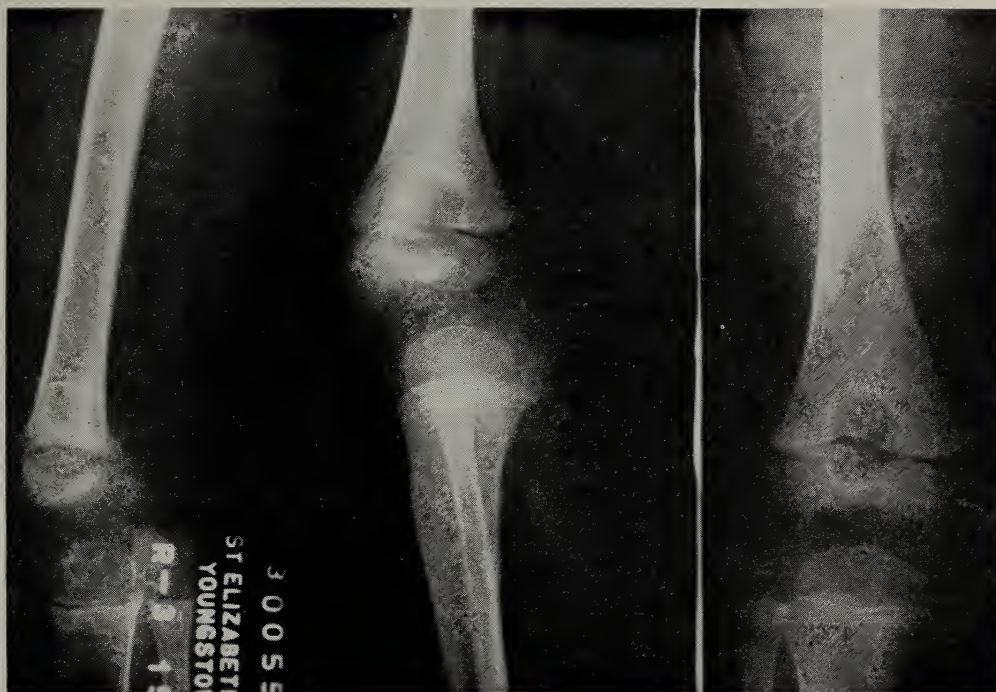


FIG. 1. X-ray shows a cystic lesion crossing the distal epiphyseal line of the femur.

complete blood cell count were within normal limits. *Operation:* A clinical diagnosis of tenosynovitis of the tendoachillis was made. Under anesthesia, the foot relaxed and was passively put through a full range of motion. A short leg cast was applied with the foot in dorsiflexion.

*Postoperative Course:* The patient seemed relieved of pain until the second night after the application of the cast. He continued to have night pain until the cast was removed a week later. There was no redness of the heel upon removal of the cast, but there was slight swelling present. Aspiration and injection of hydrocortisone into the swollen area was considered, but an x-ray was taken first. This showed fraying of the apophysis of the right os calcis (Fig. 2). A complete blood count was again normal while sedimentation rate was 36 mm. in one hour.

*Second Operation:* A preoperative diagnosis of bone cyst of the apophysis of the right os calcis was made. The second operation was about two weeks after the first one. A 3 inch perpendicular incision was made on the posterior aspect of the right os calcis. A bulge deep to the fascia was immediately noted. When this was opened, about two ounces of serosanguineous fluid escaped. A dull pink tissue resembling granulation tissue was present. Some of the serosanguineous material was submitted for culture and sensitivity tests. The apophysis of the os calcis was ulcerated and this was curetted. A section of the bone was taken for biopsy. The wound was then closed.

*Pathologist's Report:* The lesion was made up of young fibrocapillary tissue profusely infiltrated with large numbers of histiocytes, lymphocytes, eosinophilic leukocytes and plasma cells. In some areas, there were small, newly formed bony trabeculae at the periphery. In other areas, bits of old calcified bone were undergoing resorption. In other parts a transition from the histiocyte variety of cell to a spindle variety of fibroblasts was seen. Scattered throughout were considerable numbers of osteoclastic varieties of giant cells. Many of the histiocytes were swollen and filled with considerable quantities of vacuolated, presumably lipid, material. A diagnosis of eosinophilic granuloma of bone was made.

*Postoperative Course:* The patient did very well. His wound was healed within a month. He had good motion

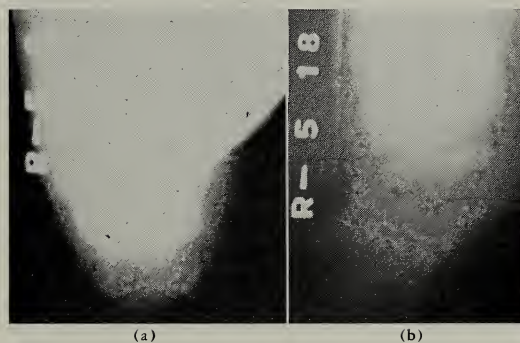


FIG. 2. Axial views of Right os calcis; (a) shows a normal apophysis, (b) fragmentation of this apophysis nine days later.

of his ankle and subastragalar joints, with no complaints. A year after surgery, x-rays of the apophysis of the right os calcis looked normal. His scar was not adherent to the underlying tissues and he had no complaints.

### Summary and Comments

Two cases of unusually located eosinophilic granuloma of bone are presented. The diagnosis in each case was made by the pathologists, since history, physical examination, x-rays and clinical laboratory findings were of no specific aid. Surgical excision of the lesions cured the condition without sequelae.

*Acknowledgment:* I am indebted to Drs. Bernard Taylor and Joseph W. Tandatnick of the Pathology Department of St. Elizabeth Hospital for the reports and for advice in writing this paper.

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# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

ROBERT G. THOMAS, M.D., *President*

## PRESENTATION OF CASE

THIS Negro man, aged 36 years, was admitted in comatose state. While at work on the morning of admission he suddenly developed weakness and nausea. The plant physician found him confused and uncooperative and referred him to the University Hospital emergency room for psychiatric evaluation. He appeared to be in a catatonia-like state, sitting on the hospital cart not speaking or moving, and his eyes did not appear to focus on moving objects. During the psychiatric examination he suddenly vomitted coffee-ground material. His respiratory rate was decreased, and at this time an endotracheal tube was inserted. This elicited no response from him. Further history obtained from his wife revealed that he had been in excellent health and at no time had he been known to have hypertension or heart disease. There was no history of excessive alcohol intake or peptic ulcer disease.

## Physical Examination

The patient was a well-developed, well-nourished Negro man, comatose, breathing with respiratory assistance. His blood pressure was 130/70; the pulse rate was 68 per minute and regular. The head had no evidence of trauma. Both external auditory canals and tympanic membranes were normal. The pupils were pinpoint, fixed, and unresponsive to light. The fundi could not be visualized. There was absence of the gag reflex. The neck was slightly stiff. The chest, heart, abdomen, and extremities were normal. On neurologic examination the patient did not respond to deep pain; deep tendon reflexes were 2-3 plus and equal throughout; there were no pathologic reflexes present on admission. The Babinski reflex was absent bilaterally, and there was no clonus.

## Laboratory Data

The hemoglobin was 11.2 Gm., the white blood cell count 18,800 with 74 per cent neutrophils and 26 per cent lymphocytes. The urine, the serum elec-

Submitted March 23, 1965.

## Presented by

- Judson S. Millhon, M.D., Columbus, and
  - Emmerich von Haam, M.D., Columbus.
- Edited by Dr. von Haam.

trolytes, and the blood urea nitrogen had normal values. The spinal fluid contained 17,750 red blood cells and 38 white blood cells per cu. mm., with 60 per cent neutrophils; protein, 215 mg./100 ml.; sugar, 73 mg. with simultaneous blood sugar of 180 mg./100 ml. Smears of the spinal fluid were negative on Gram stain and stain for acid-fast organisms, and cultures yielded no growth.

## Hospital Course

Immediately after admission a lumbar puncture was performed, which demonstrated an opening pressure of 300 mm. H<sub>2</sub>O. A tracheostomy was performed, and treatment with hypothermia was begun. When neurologic examination was repeated approximately four hours after admission, the patient responded to painful stimulus with adduction of the thighs and slight flexion of the upper extremities. Deep tendon reflexes were increased throughout, and the Babinski reflex was now present bilaterally. No clonus was demonstrated. At this time he had a pulse rate of 50 per minute. No electrocardiogram was obtained. Eighteen hours after admission neurologic examination again demonstrated bilateral decerebrate withdrawal. The patient continued to have bilateral Babinski and hyperactive reflexes, but the nuchal rigidity was absent.

The patient's blood pressure remained relatively stable until approximately 12 hours after admission, when he became hypotensive with a systolic pressure of 84 and a diastolic of 70. At this time treatment was started with a slow Aramine® drip, with good response of his blood pressure. During



his last 12 hours he no longer responded to Aramine and required Levophed.<sup>®</sup> The hemoglobin and hematocrit remained stable. The patient became anuric. His coma progressively deepened, and he showed flaccid paralysis. He died 48 hours after admission.

#### CLINICAL DISCUSSION

DR. MILLHON: This is a very interesting case and I think it holds interest in more than one respect, primarily because we are dealing with a patient who from a laboratory and x-ray standpoint provides us with a minimal amount of information. I think the only way you can approach this is to make some attempt to develop the pathogenesis and then suggest a diagnosis.

#### Abrupt Onset — Rapid Course

As you know, this was a 35 year old Negro man who rather suddenly — I want to underline this — or at least within the course of one to three hours, became comatose, required a tracheostomy, and within three or four hours of the onset of his illness demonstrated evidence of decerebrate rigidity. We are informed from the protocol that his previous medical and neurologic history was entirely negative. I think the significant laboratory data are that he did have a bloody spinal fluid with a tremendous elevation in his spinal fluid protein, that he had some peripheral leukocytosis, and a relative depression of his spinal fluid sugar. As you know, the patient died 48 hours after admission, in shock, with bradycardia and respiratory failure, again implying that his "living center" so to speak, his medullary-pontine area, had been involved in his disease process.

I think there are some really important facts absent from the protocol that could help us in the differential diagnosis. One of these would be the absence of any headache during the interval of two to three hours in which he was seen by the plant physician and referred to the University Hospital. Another important fact is a complete absence of any previous neurologic complaints. These may include headaches, personality changes, and evidence of weakness or any sensory deficit. There is no mention of any visual disturbances, any coordination disturbances, or any auditory symptoms prior to his catastrophe or at least during the two to three hour period when he was being transferred from the plant to the emergency room. Certainly the absence of any previous infectious diseases, or fever, or systemic manifestations is important, as is the completely negative general physical examination. I think this remarkable lack of symptoms should become more important as one develops the differential diagnosis further.

This man's clinical picture was ushered in with confusion, disorientation, mutism, decreased motor activity, nausea, and weakness. Again, he had no focalizing or lateralizing neurologic signs during this

three-hour period between the plant and the emergency room. He was unresponsive at the time of the tracheostomy; he had an absent gag reflex. Within four hours he became decerebrate. This *must* place the lesion somewhere in the pons or the medullary area. With his fixed, small pupils which were unreactive to light, it must be below the Edinger-Westphal nucleus of the oculomotorius. So all his clinical manifestations point to a rapid onset of severe brain-stem malfunction with obvious serious consequences.

#### Brain Stem Lesion

His deep tendon reflexes early in his admission were reported as 2 to 3 plus, and probably within normal limits, but within a short period of time he had hyperactive reflexes and bilateral Babinskis, again implicating the brain stem in the pontine-medullary area. The onset of nausea and his vomiting of coffee-ground material also implicate the medullary area, because it has been shown that the so-called stress ulcers can occur rapidly. So I think from a clinical standpoint we have to say that our focus of attention goes toward the brain stem.

Such a process obviously could be formed by something supratentorially, but at no place in this protocol are we able to develop any propagation suggesting supratentorial or hemispherical disease with secondary brain-stem malfunction. He did not go through a so-called uncal phase where you get first dilated pupils; he did not go through the diencephalic or the central stage in the propagation of his illness. When the entire clinical picture is therefore evaluated, again I think we have to implicate the pontine-medullary area around the fourth ventricle.

#### Elevated CSF Protein, Low Sugar

I think there are two significant facts in this protocol that should be emphasized. While the protocols of most clinicopathological conferences are loaded with laboratory data, this one is deficient in much, or any, laboratory information. I think that the general laboratory picture we have on this man can be ignored with the exception of the spinal fluid protein and the spinal fluid sugar. I think his peripheral leukocytosis can easily be explained as a stress phenomenon. Many people with bleeding in the intracranial cavity will have peripheral leukocytosis. But his elevated spinal fluid protein is something that calls your attention immediately.

His red cell count in the spinal fluid was only 17,000. In most people 750 to 1000 red cells will elevate the spinal fluid protein 1 mg. Discounting the protein of these 17,000 cells, you still have a protein in this spinal fluid of approximately 200 mg. per 100 ml. It is true that intracerebral bleeding, intrapontine bleeding, can sometimes produce an elevation in the spinal fluid protein because of irritation of the subarachnoid area, but again I don't think

this is the case in this patient. So we have to try to explain his elevation of cerebrospinal fluid protein.

The differential diagnostic possibilities of elevated spinal fluid proteins are fantastic, as you know, but it must be attempted. One fact that I would like to state here is that normally the spinal fluid sugar content is at least two thirds of the peripheral blood sugar content. In this man, his peripheral blood sugar was 180 mg.; two thirds of this should be 120. So if the laboratory is correct, his spinal fluid sugar is relatively depressed, and this makes the differential diagnosis easier because only a few things will depress the spinal fluid sugar. Obviously, the bacterial and fungal infections, including tuberculosis of the central nervous system, markedly depress the spinal fluid sugar. Systemic hypoglycemia is also reflected by hypoglycemia of the spinal fluid, and according to the recent literature any type of meningeal carcinomatosis, leukemias, lymphomas, or sarcomatosis will depress the spinal fluid sugar.

Subarachnoid hemorrhage itself will depress the sugar occasionally and only transiently. Some people feel that this might be on the basis of glycolytic enzymes produced from destroyed red cells, while others feel that the sugar may be depressed because of an alteration of the blood-brain barrier preventing peripheral sugar from diffusing into the spinal fluid, as in meningitis. Tumors to the meninges are notorious for depressing the spinal fluid sugar, usually below 40 mg. per 100 ml. Again, this can be explained on the basis of increased glycolysis, on the basis of the metabolism of these cells. Many tumors have been implicated in this phenomenon but the most common are the ones I have mentioned.

### Intracerebral Hemorrhage

So in attempting a differential diagnosis in this patient, I think we have to mention five conditions and try to select the one that would best fit this apoplectic syndrome which caused death in this 36 year old man. Intracerebral hemorrhage obviously has to be considered. According to Dorothy Russell's criteria, a significant intracerebral hemorrhage means a hemorrhage greater than 3 cm. in diameter in the cerebral hemispheres and 1.5 cm. in diameter in the brain stem, but in these situations arteriosclerosis or hypertension is observed in at least 70 per cent of the patients. Our patient did not have hypertension.

Obviously you have to include among the factors causing intracerebral hemorrhage the possibility of vascular anomalies. I will discuss the aneurysms when I talk about subarachnoid hemorrhage but will consider at this point arteriovenous anastomoses. Again I think that if this man's initial neurologic deficit at the time he asked for help at the factory had been an intracerebral hemorrhage, I would expect to be able to find some evidence of a focal neurologic lesion involving the extremities at the

time he was seen in the emergency room or shortly thereafter. Most of these hemorrhages occur in the paraganglionic area; most of these are associated with some hemiparesis although the patient may be completely comatose. Obviously an extensive intracerebral hemorrhage could have broken into the ventricles and produced the pontine-medullary syndrome that we see here with decerebrate rigidity.

But again, we did have an opportunity to observe this man three or four hours prior to his complete medullary failure. He was sitting in the emergency room on a cot, he walked to the physician in the plant, and there was apparently no evidence from any observer of any focal or lateralizing neurologic signs. If this man had an intracerebral hemorrhage I would expect it to have occurred in the posterior fossa or beneath the tentorium cerebelli. But at least 70 per cent of these patients with a pontine hemorrhage would have been severely comatose within 30 minutes. This man had had more time than you would expect.

### Cerebellar Hemorrhage

On the other hand, if this had been a cerebellar hemorrhage — and again both of these are associated most frequently with hypertension — you might have expected some ataxia or some conjugate eye movement difficulties to point your attention towards the cerebellum. These were absent during the three to four hours prior to his admission to the hospital. If we are going to implicate the posterior fossa and are considering a pontine or cerebellar hemorrhage, we are again faced with the abnormally high spinal fluid protein. It is true that a pontine hemorrhage can cause irritation and destruction of the pons and thus elevate the protein, but this man's protein was far in excess of the red count in his spinal fluid. However, the clinical picture could fit with an intrapontine hemorrhage, with his fixed pupils and the rest of his neurologic signs.

### Intracranial Tumor

I think that an intracranial tumor must definitely be considered in the differential diagnosis. Again the complete absence of any premonitory neurologic signs speaks against the presence of an intracranial tumor. It is true that many tumors will suffer massive bleeding, often leading to a sudden death. Probably most commonly this would occur in a glioblastoma multiforme; they will bleed into a cystic space. The elevated spinal fluid protein would fit well in this case. But again, if we believe the protocol that this man was perfectly well, it is hard to support such a diagnosis, since tumors showing such a severe initial hemorrhage are exceedingly rare. In addition, this patient was apparently well, he apparently had had neither generalized signs of a brain tumor, such as headache, dizziness, mental aberration, nor had he had any local signs of a mass lesion, either in



his previous history or during that two or three hour observation period. So if you consider the spinal fluid sugar, if you consider his clinical history, I would be quite surprised if his terminal episode was caused by a previous intracranial neoplasm.

### Subarachnoid Hemorrhage

The big complex of a subarachnoid hemorrhage also falls within the differential diagnosis of this case. Subarachnoid hemorrhage is not a disease but a symptom, and it has many causes. Probably 60 per cent of so-called subarachnoid hemorrhages are caused by leakage or rupture of a berry aneurysm, and it is true that 90 per cent of persons with a berry aneurysm suffer from so-called idiopathic subarachnoid hemorrhage. These are the "silent aneurysms" which rupture suddenly. If there are preceding symptoms, they are caused by focal pressure on the cranial nerves, particularly the oculomotorius, or by focal pressure on some particular parts of the cerebral hemispheres. But the majority of them will rupture with no premonitory signs or symptoms. Again the thing that is decisive in this case is the elevated spinal fluid protein. If the protein of the spilled or leaked red cells is discounted, the spinal fluid protein will be normal in the majority of people with subarachnoid hemorrhage. The spinal fluid sugar is also invariably normal.

Subarachnoid hemorrhages in a very high per cent will produce severe headaches; even if the patients are comatose they will be holding their heads. This man had three hours during which he was mute, with reduced motor function, but he had no lateralizing signs and there was no implication that headache was a problem during those initial three hours.

There are many other causes of subarachnoid hemorrhage besides aneurysms, such as trauma, blood dyscrasias, vasculitis as seen in collagen diseases, and tumors. Subarachnoid hemorrhages in cases of blood dyscrasias often evoke symptoms of cortical dysfunction due to injury to the gray matter, and many of these people are spastic or have epileptiform seizures. Finally, if we think of a subarachnoid hemorrhage from a ruptured berry aneurysm, we must localize it in the posterior fossa, where berry aneurysms are statistically quite rare.

### Inflammation

Lastly, we also must consider the presence of an inflammatory disease as the cause of this sudden catastrophic picture. But we were told that all spinal fluid cultures were negative, that all smears were negative, and I believe that the spinal fluid sugar was probably not low enough. In addition, there were no premonitory signs or symptoms of an inflammatory disease of the central nervous system.

So I think in summary I would like to stress that the clinical picture reflects a severe insult, the rapid onset of a disease in the posterior fossa below the Edinger-Westphal nucleus characterized by decerebrate

rigidity, bilateral Babinskis, hyperreflexia, nausea and vomiting, bradycardia, respiratory failure, and death. Again I don't think we can deduce from this clinical protocol the etiology of his disease. I think it could have been an intrapontine hemorrhage that had ruptured into the fourth ventricle. I think that in the absence of any headaches or of any focal signs implicating the cerebellum, we are dealing here with a tremendous outpouring of blood inside the cranial vault, involving at least the fourth ventricle, from some underlying process that would produce bleeding.

If such an underlying process that produces bleeding was present, and since the spinal fluid protein was markedly elevated, and since the spinal fluid sugar was relatively depressed, we have to consider some carcinomatous metastasis to the meninges or the ependyma of the ventricles. However, we have no clinical evidence of a primary malignant tumor in this patient. I think that is as far as you can go in the differential diagnosis of this case.

### CLINICAL DIAGNOSIS

1. Massive intracranial hemorrhage involving the fourth ventricle, pons, and medulla, with complete decerebration.
2. Metastatic carcinoma to meninges or ependyma, type and site unknown.

### PATHOLOGIC DIAGNOSIS

1. Osteogenic sarcoma of the third right rib with extensive metastasis.

### DISCUSSION OF PATHOLOGY

DR. VON HAAM: The autopsy of the head showed a massive hemorrhage which had perforated into the ventricles, including the fourth ventricle, caused by a tumor mass in the parietal lobe. Microscopic section of the edge of the tumor mass showed that it was apparently a metastatic lesion causing a massive hemorrhage as Dr. Millhon suggested. So we had to look for the primary tumor. As we opened the chest we found a tumor on the right chest wall which had originated in the third rib and grown into the lung. It was of considerable size and obviously could have been detected by x-ray. It is remarkable that this fellow could have gone around with a tumor like this, apparently in perfect health. We also found other tumor masses that were obviously metastatic.

In the lung there were two metastatic tumor masses. When we looked at this tumor with the microscope we found these fantastic, grotesque cells which formed angiomatous spaces lined by tumor cells. In the pleura the tumor was not so hemorrhagic, but it formed cell nests which resembled in some respects a carcinoma. The liver also contained metastases which were extremely hemorrhagic, and here again the tumor showed these very atypical tumor cells. Similar metastases were also observed in the spleen and kidney. Nests of tumor cells were found in the

bone marrow of the vertebrae. So we obviously have before us a tumor which metastasized primarily by the blood stream, as is the case with most malignant bone tumors.

Examination of the primary tumor of the third rib showed it to be a highly undifferentiated osteogenic sarcoma with areas of typical osteoid substance, atypical spindle cells, and the formation of angiomatous blood spaces lined by tumor cells. Other sections of the same bone showed evidence of old callous formation with the formation of new bone spicules lined by young osteoblasts.

From this I concluded that this patient had a

broken rib, which he perhaps never knew about, and which developed during its healing process an osteogenic sarcoma of the hemorrhagic or aneurysmal variety. It metastasized widely and caused the fatal intracranial hemorrhage. Young persons like him usually develop seminomas, osteogenic sarcomas, Ewing type of sarcomas, or lymphomas. Of these four, he had the rarest of all—an osteogenic sarcoma. It proves that a malignant tumor can sometimes cause sudden death, and I am very glad that Dr. Millhon included this possibility in his discussion. Of course I don't blame him for not mentioning an osteogenic sarcoma as the primary tumor.

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**THREATENED AND HABITUAL ABORTIONS.**—During a 31-month period, oral medroxyprogesterone acetate was used in 43 cases of pregnancy in which women showed signs of threatened abortion or had a history of habitual abortion. The over-all result was favorable in 70 per cent as evaluated in terms of live and healthy babies, without any inconvenience for the mother or the child. This result was somewhat lower than that expected on the basis of previous studies; this was attributed to the fact that women from a free public clinic and from private practice were treated, and no selection of patients was attempted, the aim being to realize the most realistic clinical picture possible. None of the women showed intolerance to medroxyprogesterone. There were no apparent harmful side effects to mother or infant, and no evidence of virilization of female infants; post-maturity was not a problem. It appears that medroxyprogesterone used at doses consistent with physiological needs, under routine and well defined clinical conditions, deserves being preserved in the therapeutic armamentarium of antiabortive treatment.

The author (1) summarized data concerning frequencies of normal pregnancies occurring after an abortion or habitual abortions, (2) outlined the role of hormones in maintenance of a normal pregnancy, and (3) pointed out that, according to various reports, use of progestins seems justified in cases of threatened or habitual abortion. He stated that medroxyprogesterone is a progestational agent that is extremely active per os and clinically exempt from androgenic or estrogenic effects. It should be 80 to 120 times more active than progesterone given orally.

Twenty of the women were treated at a public free clinic, being given medroxyprogesterone (10 to 40 mg/day, usually 30 mg/day) as soon as manifestations of symptoms of abortion appeared. Medroxyprogesterone was prescribed anywhere from 10 days to 17 weeks. There was one case of ectopic pregnancy, which was not considered in the results. In the remaining 19 women, there were eight abortions, one of which was voluntary after a decrease in abortion symptoms. In 11 cases, pregnancy developed until delivery of 11 living babies; one boy weighed only 2 lbs. and 1 oz. and died after a few hours, and this case may be considered as a failure in relation to the others. The favorable result in this group was 57.9 per cent, corrected to 55.5 per cent.

Twenty-two other pregnant women were treated at a private clinic by one doctor. They were given medroxyprogesterone (10 to 39 mg/day, usually 10 mg/day) either because of very early indications of possible abortion or because of their obstetrical antecedents. Medroxyprogesterone was prescribed anywhere from 5 days to 26 weeks. During 25 treated pregnancies, there were six abortions and 19 deliveries of live babies, which weighed between 5.1 and 9.2 lbs. The favorable result in this group was 76 per cent. — (ABSTRACT), Michel J. Berard, M. D., Montreal: *Canadian Medical Association Journal*, 91:212-218 (August 1) 1964.



# Maternal Deaths Involving Anesthesia\*

By the OSMa COMMITTEE ON MATERNAL HEALTH

## With Comment of Consulting Anesthesiologist

SINCE the last article of the same title was published in this column, July 1961,<sup>1</sup> the Committee has continued its program to study all maternal deaths in Ohio, and in addition it has pursued and maintained many projects designed to disseminate information gleaned from the study. The investigation into maternal deaths due to anesthesia has not been neglected.

With the development of a data processing system employing IBM equipment, specific statistics are now available from the volume of cases comprising the Ohio Maternal Mortality Study.

In this article the Committee presents three interesting cases of maternal deaths due to anesthesia; a comment of the Committee is published below each case. One deals with regional anesthesia, while the other two involve inhalation anesthesia. All patients were delivered by the vaginal route; cesarean sections are omitted.

Second, the Committee offers some interesting statistics on "anesthetic deaths," from the first seven years of the Ohio Study. And finally, a research project explored for a number of years by the Committee is briefly presented.

### Case No. 746

This was a 32 year old, white primigravida who died 43 hours postpartum. Her past history was noncontributory; prenatal care was considered adequate with 13 visits, and there were no complications.

At term on June 17, the patient was admitted to the hospital in labor. Premedication consisted of Demerol® 100 mg., Sparine® 25 mg. and scopolamine 1/150 grain. Four hours later Demerol 50 mg. was administered again. As labor progressed the amnion was ruptured artificially at 4:00 p.m. The patient was removed to the delivery room after eight hours of labor, where a physician administered a spinal anesthesia of Pontocaine® 6 mg. The effect was not productive of anesthesia, so cyclopropane was administered. At 6:00 p.m., spontaneously, a living 8 lb. 4 oz. baby was delivered over a midline episiotomy—soon hypoxia and vasomotor collapse developed. Details of treatment are not

recorded. The third stage was reported normal except for the generally critical condition of the patient. She remained unconscious developing convulsions at 8:00 p.m. Further details are not reported. The patient pursued a downhill clinical course and died at 12:55 p.m., June 19. An autopsy was performed.

*Cause of Death (Coroner's Autopsy):* Hypoxia and vasomotor collapse (clinical), due to postpartum (term delivery) aseptic (nonspecific) leptomenigitis. (Culture of spinal fluid: No growth aerobically or anaerobically.)

### Comment

With interest, the Committee studied this case evaluating all available information. Members regretted the paucity of details surrounding the administration of the anesthetics, as well as the 24 hour period following. In view of the facts available in the case, members felt the patient sustained an untoward reaction to the agent administered "intraspinaly." The quality of the agent used was only a matter of conjecture. After prolonged discussion, the Committee voted this a preventable maternal death.

### Case No. 543

This patient was a 26 year old, white, primigravida who died one and one-half hours postpartum. Her past history was negative. The prenatal course was normal with 10 visits; care was considered adequate. At term, on September 17, the patient was admitted in labor; according to the records no medication was administered. Her labor covered six hours and the membranes ruptured several minutes before delivery. At 10:11 p.m., September 17, a living 7 lb. 7 oz. baby was delivered, low forceps over an episiotomy. A physician administered nitrous oxide; the anesthetic record and additional details were not available, although the patient's temperature, pulse rate and respiratory rate were reported normal when the anesthetic was started.

The third stage of labor was uncomplicated; repair of the episiotomy was completed, but the time consumed was not recorded. Suddenly the patient became cyanotic and apparently she developed a cardiac arrest; breathing ceased. Adrenalin® was injected intracardially, the chest was quickly opened and the heart massaged. There was no intubation. A thoracic surgeon was summoned, and a defibrillator was used to combat fibrillation. Although the heart beat was restored, respirations were never restored. At 1:07 a.m., the heart ceased and the patient was pronounced dead. An autopsy was permitted.

*Cause of Death (autopsy):* Status postcardiac massage for cardiac arrest, following delivery. (Microscopic sec-

\*A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

tions from the lung, heart, kidney, *etc.*, all failed to demonstrate significant changes. The brain was not examined.)

### Comment

With regret that more details were not available the Committee studied facts in the case. Cyanosis and anoxia developing suddenly during administration of the nitrous oxide, apparently indicated airway obstruction, and/or deficient oxygen in the gaseous mixture. Exactly when this was discovered is not indicated in the information presented. The Committee voted this a preventable maternal death.

### Case No. 937

This was a 22 year old, white, primigravida who died five and one-half hours postpartum. Previous surgery recorded only a repair of the left patella; past history was otherwise negative. The patient registered with her physician early in her pregnancy and made regular periodic visits. Prenatal care was considered adequate; sole notation of abnormality noted on physical examination revealed the patient to be highly apprehensive, and nervous. More frequent visits to her physician seemed to control this feature. No other complications were recorded.

The patient went into spontaneous labor June 29, and was admitted to the hospital at 1:05 p.m. Labor progress was slow, and the patient complained bitterly of backache. She failed to cooperate, "bear down," and cried, "I'm sure I'm going to die!" Soon Dramamine® 100 mg. was administered slowly, intravenously. No other premedications were mentioned. After nine hours of labor she was removed to the delivery room with the cervix completely dilated, membranes ruptured. The patient was induced by mask into anesthesia, by a physician. Cyclopropane 800 cc. was given along with 2½ liters of oxygen and 2 liters of helium.

With axis-traction outlet forceps, a live 9 lb. 3 oz. baby was delivered over a midline episiotomy; the baby was depressed, cyanotic and limp, but survived after intubation and resuscitation. Meanwhile the anesthetist noted the patient's blood pressure dropping; shock developed. Quickly the extended episiotomy was repaired. But the patient's condition remained critical; she developed irreversible shock (amount of blood loss not recorded). Despite all heroic efforts in therapy, the patient died at 3:15 a.m. An autopsy was performed.

*Cause of Death (autopsy):* Shock, irreversible, due to adrenal insufficiency, due to hysteria; pregnancy delivered; acute hydronephrosis.

### Comment

The Committee noted with gratitude the completeness of details presented in this case. Older members gravely commented on the strange (nonscientific) significance of the patient's statement, "I'm sure I'm going to die!" However, after prolonged discussion, members felt that the response to Dramamine, followed by cyclopropane anesthesia would be sufficient to explain the cause of death, rather than hysteria. The case was voted a preventable maternal death.

### Comment of Consultant

The following comment of a consultant, who is a specialist in Anesthesiology, was given at the request of The Committee:

"As a consultant, it was very interesting to review the draft of this article. Indeed, it was astonishing to note two features, e. g. (1) that 54 deaths in the seven years (8.6 per cent) were due to anesthesia, and (2) that the Committee frequently has so little information to study in each case.

"Pursuant to request, I have a few additional comments on the three cases. First, I note that all three patients were *primigravidae*.

"Case 746. Available information is inadequate! When was the spinal anesthesia administered? Apparently, no continuous intravenous fluid was running before, during, or after the spinal. Blood pressure and pulse rate were *not* recorded, or the record was lost. Likewise, therapy for the 'collapse' was not reported. How much blood did the patient lose? The baby was delivered at 6 o'clock; thereafter the mother remained unconscious and developed convulsions in two hours. Much is left to conjecture, although the meningitis may have been due to a local reaction of the drug administered intraspinally.

"Case 543. First, I would surmise that the patient had *no* premedication, not even atropine! Since an anesthetic record form was not available for study, it appears this patient was *in no way* prepared to receive *any* anesthesia; she may have eaten a meal recently! Obviously, as the Committee observed, the patient was not ventilated, electrolytes therefore were out of balance, serum potassium became elevated and cardiac arrest occurred. Respirations were never restored suggesting persistent acidosis. Unfortunately, the brain was not examined; under these conditions, one expects to find dilated vessels and cerebral edema. Either the emergency was not recognized when it arose, or it was treated inadequately, or both.

"Case 937. What depressed the newborn baby? Again, it would appear that additional premedication (atropine) was indicated before an inhalation anesthesia was administered. Somehow, I feel certain facts have been omitted from the (already short) story in this case. I am not familiar with all of the untoward reactions associated with the administration of Dramamine®. However, its physiologic action on smooth muscle is believed to be similar to Benedryl®, and Novocain® administered intravenously. Also, I am not clear on the *amount* of time required to administer the stated quantity of cyclopropane.

"In closing, I reiterate the slogan of an outstanding teacher of anesthesia, 'Death is a high price to pay for a few minutes of pain relief, during childbirth.'"

### How Many Deaths?

Periodically, the Chairman receives requests for information concerning maternal deaths in Ohio following obstetric anesthesia. Queries are also received related to Ohio Laws regulating a nurse and her qualifications to administer anesthetic to an obstetric patient.

A small study ("IBM Project No. 37") was devised to elicit some interesting points on the subject. Cases falling into the first seven years, 1955-1961 were examined by data processing methods. During this period of time, the Committee on Maternal Health studied 870 cases in the Ohio Study. Of



these, 623 were voted into a category of *maternal deaths*. Total Live Births during the period were 1,627,221.

Table 1 shows the four categories of 612 maternal deaths during the period. Under "other causes,"

TABLE 1. *Primary Cause of Death, 623 Maternal Deaths, Ohio Maternal Mortality Study, Seven Years, 1955-1961.*

Cause of Death	No. of Cases
Hemorrhage .....	158
Infection .....	117
Toxemia .....	73
Other Causes .....	275
Cause Undetermined .....	1
Total .....	624

of miscellaneous diagnoses, there were 54 maternal deaths (8.7 per cent) involving *anesthesia*.

Curiously enough, the great majority of these cases (32) received a *general anesthesia* (Table 2).

TABLE 2. *Type of Anesthesia, 54 Maternal Deaths Due to Anesthesia, Ohio Maternal Mortality Study, Seven Years, 1955-1961.*

Type of Anesthesia	No. of Cases
General Anesthesia .....	32
Regional Anesthesia .....	21
Other .....	1
*Total.....	54

\*Included in 275 Other Causes, Table 1.

Searching a bit further we chose to find the type of anesthetic route of administration employed in each of the 54 cases; this was slightly more difficult because in 10 or more instances, *more than one agent* was used during the delivery (see Case No. 746).

As previously mentioned, above, the three cases reviewed represent only vaginal deliveries. However, statistics in the accompanying tables represent *all* deliveries, including cesarean sections. Whereas

TABLE 3. *Anesthetic Route Employed, 54 Maternal Deaths Due to Anesthesia, Ohio Maternal Mortality Study, Seven Years, 1955-1961.*

Anesthetic	No. of Cases
None .....	2
Inhalation .....	27
Intravenous .....	10
Caudal .....	1
Spinal .....	18
Saddle .....	5
Local or other .....	0
Not Known .....	1
*Total.....	64

\*(10 patients, more than one agent was used)

the predominant route of administration was *inhalation* (27 cases), the next routes in order were *spinal* (18 cases), and *intravenous* (10 cases). (See Table 3.)

Last in our brief survey, we sought to ascertain *who* administered the anesthetic agent to the 54 patients. Results are tabulated in Table 4, revealing the fact that physicians gave the majority of anesthetics (36), most all of which (34), were physicians *not* participating in the delivery itself. Very few

TABLE 4. *Individual Administering Anesthetic, 54 Maternal Deaths Due to Anesthesia, Ohio Maternal Mortality Study, Seven Years, 1955-1961.*

Individual	No. of Cases
Not Known .....	7
Delivering Physician .....	2
Other Physician .....	34
R. N., General Duty .....	6
Registered Nurse Anesthetist .....	5
Total .....	54

anesthetics (6) were given by general duty registered nurses, while in seven cases, the individual, by title, was not recorded.

Committee Functions

Under due authority assigned by The Council, the Committee on Maternal Health assumes three principal functions:

1. *Statistical.* The Committee conducts a continuous state-wide Maternal Mortality Study of all maternal deaths in Ohio on an anonymous basis. Information and data on all cases are gleaned as completely as possible, and are transcribed onto standard cards through the IBM data processing system.

2. *Educational.* The wealth of statistical and clinical data derived from the Ohio Study is utilized by the Committee and its individual members in a "broad-spectrum" education and training program, throughout many medical and paramedical avenues. Details of this phase of activity have been discussed in this *column* previously.

3. *Advisory.* The Committee on Maternal Health acts as an advisory body to The Council, in matters pertaining to Maternal Health in Ohio.

As early as November 16, 1960, under approval of Council, the Committee named a subcommittee from its membership, at the request of the Director of Health, to work closely with him under an advisory capacity in a revision of the Ohio Maternity Hospital Licensure Program. On call, this subcommittee continues its function.

Obstetric Anesthesia

Over a period of years, one of the many "thorny problems" referred to the Committee for study and recommendation is that of *obstetric anesthesia*. In its annual report for 1955,<sup>2</sup> fourteen maternal deaths due to anesthesia were listed, and again for 1959<sup>3</sup> the Committee noted 11 maternal deaths due to anesthesia. Although the number of deaths in this category has varied during the intervening years, The Council has evidenced deep concern in this phase of the Ohio Study.

Further pursuit into the problem was launched by the Committee in conjunction with District V, ACOG during 1959.<sup>4</sup> The purpose of this survey was to ascertain current methods and practices employed in obstetric anesthesia in Ohio.

Not only was the problem associated with the number of mothers dying under anesthesia, but also

it extended through the interpretation of the Ohio Code, for maternity hospitals, concerning the administration of obstetric anesthetics. This section of the Code follows:

Sec. 4731.35 (1286-2). Registered nurse may administer anaesthetic.

Sections 4731.01 to 4731.47, inclusive, of the Revised Code shall not apply to or prohibit in any way the administration of an anaesthetic by a registered nurse under the direction of and in the immediate presence of a licensed physician, provided such nurse has taken a *prescribed course* in anaesthesia, at a hospital in good standing.

To add zest and interest to the "OB-Anesthesia" matter, administrators and key physicians in various Ohio Hospitals frequently wrote to the Ohio State Medical Association requesting information on the subject as it applied locally, and a great many pleaded clarification of the "law" in order to conform to the Ohio Code. Indeed, at times, the Ohio Department of Health, in the past decade has considered conscientious implementation of the Ohio Code, as a vicarious vagary.

### Research and Recommendations

Also during the past decade, The Committee on Maternal Health has received these questions and problems for prompt study and recommendations. Of great assistance to the Committee in studying each question was the close liaison established with the Ohio Department of Health, through its subcommittee. Weeks of coordinated effort in research, discussion and deliberation generally preceded recommendations before referring them to Council for approval.

On January 8, 1961, the Committee crystallized results of its investigation by forwarding a four-point recommendation to Council; the resolution clarified certain vague points in the project. It was approved.

A number of additional queries followed this action. Now it appeared that hospital administration staffs wished specific clarification of a "*prescribed course*" as published in Section 4731.35 (1286-2) of the Revised Code.

On January 28, 1962, in response to specific requests, members of the Committee individually and collectively, embarked on a systematic program aimed to solve this lingering problem, e. g., "a prescribed course." A subcommittee was appointed; the Ohio Society of Anesthesiologists<sup>5</sup> and the Ohio Department of Health were invited to participate in the joint effort.

During the ensuing two and a half years subcommittees of the representative organizations studied the problem, investigated possibilities, and probed for an equitable solution.

### Fifty-State Survey

Meanwhile in June, 1964, a letter was prepared and sent to (49) respective Directors of Health of every additional state in the United States. The letter requested assistance in solving a complex prob-

lem involving "obstetrical anesthesia administered by a registered nurse."

Specifically the survey requested a brief statement on five issues, related to laws and requirements currently in effect in each respective state. Forty-eight replied promptly. Only nine of them had any regulation related to obstetric anesthesia; all of the nine were meager compared to the stringent Ohio Code.

After further study, the Committee on Maternal Health recommended that, "The prescribed course for nurses administering anesthesia to obstetric patients be the course as required by the American Association of Nurse Anesthetists, or its equivalent."

The following is quoted from "Bylaws — American Association of Nurse Anesthetists":

#### ARTICLE I — Membership

1. Continuous experience in the Administration of anesthetics since 1933 in approved hospitals; or,
2. Graduation from a school of anesthesia, which school,
  - a. If graduation was prior to 1939, gave a course of at least four (4) months; or,
  - b. If graduation was between 1939 and August 31, 1947, gave a course of not less than six (6) months and complied with the standards of this association; or,
  - c. If graduation was after September 1, 1947, gave a course of not less than eight (8) months and complied with the standards of this association; or,
  - d. If graduation was after January 1, 1951, gave a course of not less than one (1) year and complied with the standards of this association.
  - e. If graduation is after December 31, 1963, must have completed a course of not less than eighteen (18) months and complies with the standards of this association.

If date of graduation from any of the above courses was more than five (5) years prior to the date of application the candidate must present evidence of present clinical ability.

The Committee's recommendation on a proposed "prescribed course" for nurse anesthetists was presented to The Council on December 13, 1964, at which time The Council took no action on the resolution.

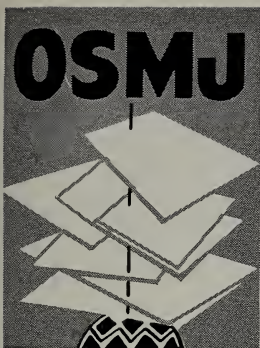
### Summary

1. In this article on obstetric anesthesia, three case reports are presented representing maternal deaths due to anesthesia.
2. A brief statistical summary is given to demonstrate features surrounding 54 maternal deaths due to anesthesia, during the first seven years (1955-1961) in the Ohio Maternal Mortality Study.
3. Research and advisory functions performed by the Committee on Maternal Health are outlined, specifically with a focus upon obstetric anesthesia.

### References

1. OSMa Committee on Maternal Health: Maternal Deaths Involving Anesthesia. *Ohio State M. J.*, 57:800-802 (July) 1961.
2. OSMa Committee on Maternal Health: Maternal Mortality Report for Ohio — 1955. *Ohio State M. J.*, 54:1458-1459 (December) 1958.
3. OSMa Committee on Maternal Health: Maternal Mortality Report for Ohio — 1959. *Ohio State M. J.*, 58:1386-1388 (December) 1962.
4. OSMa Committee on Maternal Health: Maternal Mortality Report for Ohio — 1956. *Ohio State M. J.*, 55:1671-1673 (December) 1959.
5. OSMAGram. OSMa Newsletter, July 16, 1963.





# NEWS AND *Organization Section*

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## OSMA Cites Medicare Dangers . . .

Official Statement Filed with Senate Finance Committee  
During Recent Public Hearings on \$6 Billion Legislation

**O**PPPOSITION to H. R. 6675, the Medicare bill, and a citation of the many positive programs medicine is backing to help solve the problems of the aging were outlined in a formal statement submitted to the Senate Finance Committee May 7.

The statement cited the inherent dangers in the bill from a patient care viewpoint, from an economic viewpoint, and from a philosophical viewpoint.

The statement was filed with the chairman of the committee, Senator Harry Byrd of Virginia, with information copies supplied to all other committee members as well as Ohio Senators Frank J. Lausche and Stephen M. Young.

The following is the official statement:

Senator Harry F. Byrd, Chairman  
Senate Finance Committee  
United States Senate  
Washington, D. C. 20025

Dear Senator Byrd:

In conjunction with the Senate Finance Committee hearings on House Resolution 6675, I respectfully submit to you for your consideration as Chairman of that committee, and for the committee as a whole, information pertaining to H. R. 6675.

The purpose of this statement is to provide you and your committee with (1) the position of the Ohio State Medical Association regarding H. R. 6675 and (2) some pertinent facts regarding the important work being done in the State of Ohio to cope successfully with the health problems and other problems of our senior citizens.

The Ohio State Medical Association has consistently

supported sound programs, public and private, that are helping to alleviate these problems.

This Association consistently has opposed enactment of any plan or scheme of government-controlled, compulsory health care. H. R. 6675, if enacted, would create a government-controlled, compulsory program.

Proof that a large majority supports medicine's position on this issue is found in a survey conducted by Opinion Research Corporation, Princeton, N. J., March 6 to 21, 1965, which showed 74 per cent supporting medicine's position, 14 per cent supporting Medicare and 12 per cent having no opinion.

### Reasons for Opposing H. R. 6675

This Association is opposed to H. R. 6675 because such legislation:

(1) Is a \$6-billion-plus bill written entirely in executive session and recommended for passage without giving the American people their democratic right of speaking out before the House Ways and Means Committee in free and open public hearing;

(2) Is totally unnecessary and would become increasingly costly;

(3) Would not meet the fundamental needs of the situation: namely, it would not provide the comprehensive program to meet the needs of our senior citizens who need help;

(4) Would, by making the Federal Government a direct purchaser of services, destroy the fundamental and important concept of providing Social Security dollars to beneficiaries;

(5) Would lead inevitably and irrevocably to a

system of compulsory health care for the entire population;

(6) Would lead to the eventual destruction of private and voluntary hospital and medical insurance plans;

(7) Would force into hospitals patients who otherwise could be treated on an ambulatory basis;

(8) Would enlarge an already huge Federal bureaucracy;

(9) Would work additional and unnecessary hardship on young family heads by increasing the already heavy taxes on their incomes at the time when their family needs are greatest, and

(10) Would endanger existing and necessary welfare programs since a Social Security program would likely influence Federal, state and local governments toward reducing appropriations to finance programs now in operation.

#### Inroads into Family Income Tremendous

The inroads into the family income made by the tremendous Social Security tax increase provided in H. R. 6675 would be tremendous, and would be catastrophic for some families.

The taxes deducted from the worker's pay check would represent what he spends in four months for food prepared at home for his family; what he spends in eight months for clothing for his family.

The self-employed person would be taxed an amount representing six months of expenditures for food prepared at home and 11 months of expenditures for clothing.

This can be verified by projecting spending figures printed in the December, 1964, issue of *Monthly Labor Review*, U. S. Department of Labor, "Contrasts in Spending by Urban Families."

It is brutally socialistic to seize outright this much of a family head's income to attempt to finance a program that benefits the retired millionaire as much as the deserving needy, a program that completely disregards the sound and proper philosophy of helping those who need help.

Pius XI wrote in *Quadregesimo Anno*, "It is a fundamental principle of social philosophy, fixed and unchangeable, that one should not withdraw from individuals and commit to the community what they can accomplish by their own enterprise and industry. So, too, it is an injustice and at the same time a grave evil and a disturbance of right order to transfer to the larger and higher collectivity functions which can be performed and provided by lesser and subordinate bodies. Inasmuch as every social activity should, by its very nature, prove a help to members of the body social, it should never destroy or absorb them."

The program advocated by the medical profession leaves to the individual the provision of care for himself and his family if he is able to provide such

care. Also, it provides for the person needing help the program necessary to meet his needs.

#### Dangerous to Ignore Economic Effects of Tax Increase

The overall economic effects of the huge tax increase that would be levied by H. R. 6675 cannot be ignored if this nation is to be realistic. The inherent dangers in the diversion of more than \$6 billion from present channels, particularly from the income of the worker and management, are considerable.

The economic impact of this proposal in Ohio, for example, based on Department of Commerce and U. S. Census Bureau statistics, would result in additional taxes on employee and employer combined amounting to:

\$311,600,000	in 1966, increasing to
\$376,300,000	in 1967, increasing to
\$747,300,000	in 1971, increasing to
\$992,600,000	in 1973, increasing to
\$1,010,100,000	in 1974, increasing to
\$1,190,300,000	in 1980, increasing to
\$1,394,400,000	in 1987, with continuous

increases in the intervening years.

These amounts are in addition to the present Social Security taxes. Also, these amounts do not include taxes that would be paid by the self-employed.

Another pertinent point is that these direct taxes must come from income the wage earner and self-employed now use to meet day-to-day living and family expenses. The taxes also must come from income of the employer, large or small, who needs to maintain and improve his business in order to survive in today's highly competitive market.

These figures do not take into consideration any increases in the tax rate that may be necessary to meet cost spirals in the future. History affords us the opportunity of studying the past to avoid mistakes in the future. All one need do is to study the experiences of our Canadian neighbors to realize that this bill would be a tragic economic mistake, notwithstanding the social and philosophical mistakes it would create. I respectfully call to your attention the attached Exhibit A, which affords historic fact as to the future dangers this bill would create.

This nation's Social Security System was initiated as a means of levying a small tax in order to provide our citizens with a base on which to build their retirement. It was not conceived and cannot be realistically conceived as a full retirement program or a program offering services as well as funds.

The past increases in the Social Security tax rate, coupled with the multiple and tremendous increases provided in H. R. 6675, threaten to create an overwhelming tax burden against which the American people might well revolt.

It is the opinion of the Ohio State Medical Association that our extremely important Social Security



System must be maintained and financially stabilized on its present basis, rather than be subject to unnecessary and dangerous exploitation that could threaten the entire system.

Again pointing out that history enables us to study the past as a means of avoiding mistakes in the future, I respectfully call to your attention the attached Exhibit B, which reflects past increases in both the tax rate and base as well as the many future increases provided by H.R. 6675.

### Helping Those Needing Help

The citizens of Ohio believe in helping their senior citizens who need help. This belief was demonstrated 18 months before the Social Security System came into existence when the people of Ohio voted, as the result of an initiative petition, to establish the Ohio Aid for the Aged Program. This program is and always has been wholeheartedly supported by the medical profession. I respectfully call to your attention the attached Exhibit C, which discusses the Ohio program in detail.

The present Ohio program, administered and partially financed by the state, deserves further commendation because it:

- (1) Provides comprehensive care based on proven needs and local determination;
- (2) Provides a voluntary, not compulsory, mechanism to supplement, not supplant, individual voluntary health insurance and prepayment plans;
- (3) Is a "hometown" program administered on a local basis;
- (4) Is considerably more economical, more sound and more feasible than H. R. 6675;
- (5) Preserves the physician-patient relationship;
- (6) Does not detract from the high quality of medical services through third party interference and regulation;
- (7) Helps those senior citizens who need help, rather than helping the wealthy equally as much as the needy.

The medical profession readily recognizes that a problem exists in this field. However, considering the number of senior citizens still productively employed or self-employed, plus those already covered by non-governmental health insurance, plus those who prefer to finance their own health care through their own private resources, one cannot logically conclude that a huge vacuum exists in health care of the aged. The facts speak for themselves.

### Positive Program for the Aging

Fully aware that the medical profession has a major responsibility in this field, the Ohio State Medical Association uses as a guide the following positive program:

1. Stimulation of a realistic attitude toward aging by all people.
2. Greater emphasis on health maintenance, preventative, restorative and rehabilitative services.

3. Accelerate the already expanding and effective methods of financing health care of the aged through voluntary, non-official programs and existing programs administered on a state and local basis.

4. Improvement of medical and related facilities for older people, and expansion of training programs to provide additional skilled personnel to staff such facilities.

5. More emphasis on research to help provide solutions for the health and socio-economic problems of the aging.

6. Stimulation of cooperative community programs for the aging.

American medicine and private enterprise are making great strides toward these goals, once again proving that H. R. 6675 is completely unnecessary.

### Committee on Care of the Aged

This Association long has had an active Committee on Care of the Aged. Many of the 88 county medical societies in Ohio have similar committees. The statewide committee devotes its activities to:

1. Consultation with other organizations regarding their activities involving the aging.
2. Liaison with such groups and, when requested, advice on the medical aspects of their programs.
3. Cooperation with other organizations, governmental and private, in improving health services and facilities.
4. Arousing the interests of both physicians and the public in understanding the problems of the aging.
5. Cooperation in exploring this entire area, including health, psychological, social and economic aspects.

As an example, this Committee prepared, in consultation with 17 official and voluntary agencies in Ohio, a comprehensive home care program which has been nationally recognized. Several Ohio cities, through the leadership of their local medical societies, already have established home care programs, and several others are preparing to do so. This development was a direct result of a resolution unanimously passed by the Association's House of Delegates.

### Further Emphasis Encouraged

This Association encourages further emphasis in the field of the aging through the following constructive programs:

1. Recognize and respect the aging as responsible individual citizens rather than depicting them as an 18-million-member national problem that should be walled off from society. H. R. 6675 would construct such a wall.
2. Immediate abolition of the completely unrealistic retirement-at-65 attitude. Retirement at 65 was developed by Bismarck in the past century when the life expectancy was far less than 65 years, as

compared with the present life expectancy of 70 years-plus.

3. Recognition of the skills and productive abilities of older workers, rather than arbitrarily denying them a productive, enjoyable life.

4. Much greater emphasis on mental, physical and financial preparation for retirement during the productive years. Make retirement elective, not compulsory.

5. Continued improvement in income tax laws to ease the tax burden on the low income aged and those who support them.

6. Continuation of insurance on older active workers under group plans, and continuation of group insurance on workers who retire, and their dependents.

7. Continuation, on an individual basis, of coverage originally provided by group insurance, by conversion of policy on retirement.

8. Group policies for groups of retired persons.

9. Development of insurance policies that become paid up at age 65, enabling the policy-holder to provide for his retirement health needs during his productive years.

#### Age of Prevention

I cannot emphasize too strongly the paramount factor underlying all these programs. This factor is that these programs are all preventive in nature. This is the age of preventive medicine, and the profession and private enterprise are taking the leadership by advocating these programs that either forestall the development of financial problems of the aging, or else provide the means for solution of their problems once they do develop.

In sharp contrast, H.R. 6675 merely offers a completely unsound device that has no preventive factors. Further, it is not an insurance system, but rather is a compulsory payroll tax from which, undoubtedly, the revenues will be insufficient to meet the demands.

The actuarially proven deficiencies of the intended program alone make it a dangerous and unstable venture, regardless of its many other faults.

In summary, there is ample evidence that:

1. The basic problems of the aged, which are much the same as those of any age groups, are being steadily overcome through existing welfare programs, through voluntary programs and private enterprise.

2. More and more emphasis is being placed on adjustment for the older years, medically, economically, socially and financially, through better preparation for retirement during the productive years.

3. More and more attention is being given to those concepts that enable the senior citizen to maintain his own dignity and self-reliance.

4. H.R. 6675 is an attempted hoax that, if enacted, would create far more harm than good.

5. This nation's Social Security System must be preserved. The recorded fact is that the several

amendments to the Social Security Act over the past years have added benefits to the program that consistently have proved to be far more costly than was anticipated. This has caused considerable inroads into the Social Security reserves. The money benefits retired persons are deriving through Social Security play a tremendous role in the economic well-being of this age group. It would be foolhardy to place additional jeopardy on the Social Security fund by adding another deficit program. H.R. 6675 would be another deficit program.

The Ohio State Medical Association respectfully requests that this statement be presented to the Senate Finance Committee for inclusion in the official record of the hearings on H.R. 6675.

Thank you for your courteous attention.

Sincerely,

(Signed) ROBERT E. TSCHANTZ, M.D., *President*  
Ohio State Medical Association

#### Enclosures:

Exhibit A — "Federal Health Estimates — 300% Wrong"

Exhibit B — "Social Security Tax Increases, Past and Proposed"

Exhibit C — "Aid for the Aged in Ohio"

#### Copies to:

Members, Senate Finance Committee  
and  
Senator Lausche and Senator Young

#### Eisenhower Featured in Film Entitled "Reprivee"

"Reprivee," a 16 mm color motion picture sponsored by the Public Health Service, U. S. Department of Health, Education, and Welfare, now available for public showing, offers hope and encouragement for the million-plus American men and women who each year survive a heart attack.

In the 22-minute film, former President Dwight D. Eisenhower and other heart patients, including a farmer, a mechanic and banker — all from Salisbury, Maryland — tell how sensible living habits and adherence to doctors' orders have enabled them to return to active and useful living.

For showing to groups, prints of the film, "Reprivee," can be obtained on loan free of charge by writing to the Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

#### OSU Alumni Honored

Fifty-year honored alumnus certificates were awarded to members of the Ohio State University College of Medicine Class of 1915 at the recent college reunion on the OSU campus.

Eligible to receive the certificates were 22 physicians from various areas of Ohio and seven now residing in other states.



# New York - - AMA Convention . . .

## Comprehensive Program Is in Store for Those Who Attend; Many Features Are of Particular Interest to Ohio Physicians

PHYSICIANS who attend the 114th Annual Convention of the American Medical Association in New York City, June 20-24, will find one of the most comprehensive arrangements of scientific data ever assembled in one program. Following are some of the highlights:

- Six general scientific meetings — adverse drug reactions, organ transplantation, hearing, non-narcotic drug addiction, metabolism in aging and diagnostic cytology.
- Twenty-three medical specialty programs including a new section program on allergy.
- Special sessions on nuclear medicine and maxillofacial surgery.
- Lectures, panel discussions, motion pictures and color television.

- More than 700 scientific and industrial exhibits.

An imposing program also is in store for nurses, technicians and other persons in the health sciences who plan to attend the meeting.

### Reception Honoring Dr. Hudson

One of the high points of the meetings as far as Ohioans are concerned will be the reception scheduled on Wednesday evening, June 23, at the Americana Hotel in honor of Dr. Charles L. Hudson, of Cleveland. Dr. Hudson is a member of the Board of Trustees of the American Medical Association and a candidate for the office of AMA President-Elect.

### Auxiliary Meetings and Programs

This year's president of the Woman's Auxiliary to the AMA is Mrs. William H. Evans, of Youngstown. Mrs. Evans will preside at meetings of the Auxiliary and will be honored at special functions.

For the benefit of members who bring their families to New York, special provisions have been made for children and young people. Several tours have been announced for pre-teens and teen-agers.

### Complete Program Published

The complete program of the AMA Convention was published in the May 10 issue of *The Journal of the AMA*, and readers are referred to that issue for details as to speakers, topics, times, places, etc.

Numerous Ohioans are listed as participants in the Scientific program and in the Scientific Exhibit. Ohio's delegation will participate in deliberations of the

House of Delegates and as members of various committees.

With New York City convenient for travel from Ohio, a large number of Ohio physicians is expected and many Ohio physicians will take their families. Many organization meetings are scheduled to be held in connection with the AMA Convention and the reader is referred to the same program issue of the *JAMA* for times and places of these special programs.

A number of tours also are scheduled in connection with the meeting; physicians and members of their families may be interested in arranging vacation trips before or after the meeting.

Biggest New York attraction this year obviously is the World's Fair. Many will wish to arrange trips to the fair.

The deadline for advance registration will be past by the time this issue of *The Journal* goes into circulation. Registration must be made, however, at the time of entrance. Any member, who has not made hotel or motel reservations already, is urged to do so immediately. With the World's Fair in progress, accommodations will be scarce.

### Missouri Singing Doctors' Albums Promote Scholarship Loans

Through the talents of its "Singing Doctors," three record albums of "Medical Hit Parade" satire have grossed over \$75,000 for the Greene County Medical Society, Springfield, Missouri, with all proceeds going to the Society's scholarship foundation. More than three dozen young doctors-to-be have received scholarship loans so far, and this summer additional students will be selected to receive aid.

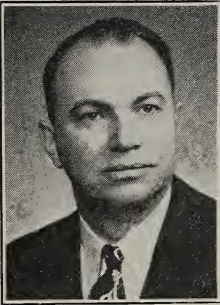
The albums—available exclusively by mail from the Society's headquarters in the Professional Building, Springfield, at \$3.25 each, postpaid—are the brain child of a surgeon, James T. Brown, M.D., who composed the 60 parodies contained in the three volumes and organized five of his fellow physicians into the now widely known group. Among their "hit parade" selections are "Black and Blue Cross," "Hemorrhoids," "I'll Try to Say No" (the "house-calls" song), "AFL - CIO - AMA," "The Menopause," "Medical School Memories," "Halitosis Beats No Breath at All," and songs dealing with each of the specialties.

# Report of OMI Annual Meeting . . .

## Dr. Yantes Elected President; Five New Members Are Named to the Board: Report of the Year's Activities

**E**LECTION OF OFFICERS, the naming of five new members to the Board of Directors, and the issuance of a report of the year's activities, were highlights of the 1965 Annual Meeting of Ohio Medical Indemnity, Inc., on April 21. OMI is Ohio's 20-year-old Blue Shield Plan and has offices at 3770 North High Street in the north end of Columbus.

Edmond K. Yantes, M.D., Wilmington general practitioner, was elected president of OMI. He succeeds H. M. Clodfelter, M.D., Columbus internist, who served as president of OMI for seven years and who asked to be relieved of that position. Dr. Clodfelter will remain on the Board of Directors of which he has been a member since 1948, having been re-elected to the Board at the April 21 meeting.



Dr. Yantes

Dr. Yantes has been a member of the Board of Directors since 1949 and was re-elected at the stockholders' meeting. He has been chairman of the OMI Executive Committee for the past seven years.

Other officers elected for the ensuing year by the Board of Directors following the regular stockholders' meeting were: Starling C. Yinger, M.D., Springfield otolaryngologist, first vice-president; Dwight L. Becker, M.D., Lima general practitioner, treasurer; Mr. Charles H. Coghlan, Columbus, executive vice-president, a post he has held since 1945 when the company was founded; Mr. Frank H. Van Holte, Columbus, vice-president (administration) and secretary. Mr. Van Holte has been on the OMI administrative staff since 1946.

Dr. Yinger was appointed by Dr. Yantes as chairman of the Executive Committee. Others named to that important committee, having been re-elected directors at the stockholders' meeting, were: Dr. Becker, Mr. Clair E. Fultz, Columbus, president Huntington National Bank; Carl W. Koehler, M.D., Cincinnati radiologist; Robert S. Martin, M.D., Zanesville ophthalmologist; Mr. Harold W. Slabaugh,

Akron attorney; Frank L. Shively, Jr., M.D., Dayton surgeon; George L. Sackett, M.D., Painesville radiologist; and Gordon L. Todd, M.D., Toledo internist.

### New Board Members

Five new members were elected to the Board of Directors as a result of votes cast by the stockholders, having been nominated by The Council of the Ohio State Medical Association acting on behalf of the Association which is the majority stockholder, in addition to 16 others who were re-elected to the Board.

New directors elected were: J. Martin Byers, M.D., Greenfield general practitioner; George J. Hamwi, M.D., Columbus internist; Sander Goodman, M.D., Cincinnati internist; William A. White, Jr., M.D., Canton internist; Mr. Francis M. Wistert, Toledo, vice-president (industrial relations), Eltra Corporation.

Those re-elected to the Board of Directors were: Mr. Ralph L. Abernathy, Dayton, district commercial manager, Ohio Bell Telephone Company; Mr. Edgar O. Mansfield, Columbus, administrator, Riverside Hospital; Mr. J. A. Meckstroth, Columbus, editor emeritus, *Ohio State Journal*; Mr. John Schoedinger, Columbus mortician; Msgr. John C. Staunton, Cincinnati; Drs. Clodfelter, Yantes, Becker, Koehler, Martin, Shively, Sackett and Todd, and Messrs. Fultz and Slabaugh.

The Board of Directors reappointed Mr. Wayne E. Stichter, Toledo attorney, as legal counsel and designated Ernst & Ernst, certified public accountants, to continue as OMI auditors for the ensuing year.

Highlights of reports submitted to the Board of Directors by Dr. Clodfelter, Mr. Coghlan, Mr. Van Holte, and various committee chairmen follow:

Ohio Medical was providing coverage for 2,352,336 Ohioans at the end of 1964. During the past year enrollment in Blue Shield Plans continued to increase, the 84 plans of the country adding 2,806,427 subscribers for a total enrollment of 55,256,776. The Blue Shield Plans now cover 26.97 per cent of the population of the country. OMI covers 29.20 per cent of the population in the 83 county areas which it serves.

OMI paid for 558,713 individual medical-surgical



services covered by its contracts during the calendar year 1964. Claim checks for these services totaled \$26,666,000.

Claims totaling in number 4,500,000 and in amount \$248,000,000 have been paid by Ohio Medical since its founding in 1945. Since its beginning 19 years ago, OMI has transmitted 634,700 checks to subscribers to help pay obstetrical charges. Many present members of OMI were "born" members, their parents having been enrolled in OMI.

OMI members are enrolled in six basic contracts. Many members also have coverages over and above the basic contracts through the purchase of riders. Actually, OMI contracts, and riders to contracts, provide 83 different degrees of coverage. This has made it necessary for the company to maintain alert and efficient Claims, Accounting, and Actuarial departments to insure administrative services of the highest standard.

### Professional Liaison

Relationship of OMI with the medical profession throughout the state was enhanced during the past year. This resulted from acceleration of the activities of the Physicians Relations Department under the direction of Mr. Charles Jarrett, and the publication of the OMI Newsletter, under the editorship of Mr. Charles S. Nelson, which has become popular among a large segment of the profession.

Many meetings throughout the state—medical society meetings, hospital staff meetings and calls at physicians' offices—have been manned by Mr. Jarrett for the purpose of answering questions about OMI and presenting information about OMI's coverages and methods of handling and paying claims. Groups who may wish to have Mr. Jarrett visit them should get in touch with the Home Office of OMI in Columbus.

The OMI Medical Advisory Committee has been enlarged during the past year, consisting at present of 31 doctors of medicine located in various parts of Ohio and representing most of the segments of medicine. This committee provides knowledge and judgment which are extremely helpful to the company in settling complicated claims and on matters relating to increases in existing OMI benefits or the addition of benefits to contracts.

Rate increases for the Standard and Preferred contracts were largely completed in 1964. This again stabilized OMI's income and outgo and the rate adjustments were accomplished without major problems from the subscribers' point of view. The report of Ernst & Ernst, OMI auditors, for the calendar year 1964 showed that OMI had a surplus of \$16,188,000 at the end of the year and that income for the year had exceeded disbursements by \$504,000.

Several members of the Ohio State Medical Association OMI Liaison Committee attended each meeting of the Board of Directors or the Executive Committee during the past year for the purpose of exchanging

opinions and information. This has been of mutual benefit to both OMI and the State Medical Association.

Enrollment in the new Comprehensive Plan now totals 32,600 persons, 11,100 having been enrolled during 1964 and 21,500 since the first of this year. This plan which provides for paying the physician's usual and customary charge to families earning \$7,500 or less has been approved by 60 county medical societies of the state. It will not be sold in any county without approval of the county medical society.

The number of persons covered by the OMI Major Medical Contract (Extended benefits) expanded slightly during 1964. Approximately 3,500 contracts were added, making the total number of contracts in force 12,600 (47,000 persons). Slow growth of this plan indicates that the average employee is more interested in having the first part of his physician's bills covered by insurance rather than in securing larger coverages for extensive professional care through the use of deductibles and co-insurance.

### Minimum Staff

OMI is doing business with a minimum number of employees to effectively service contracts and, particularly, to efficiently process claims without undue delay. It maintains a staff of 108 employees or one employee for each 9,808 contracts in force. This compares as follows with these Blue Shield Plans for example: Indiana, 8,381; Pennsylvania, 5,772; New York City, 3,333; Michigan, 3,172.

\* In 1964, 89 $\frac{1}{3}$  cents out of every OMI premium dollar were being paid out in benefits, the balance being used for operating costs and to strengthen reserves.

The original report shows the distribution of OMI enrollment by type of contract throughout the seven Blue Cross areas of Ohio. It compares the distribution as of December 31, 1964, and December 31, 1963. There was an upgrading of many thousands of contracts from the original "Standard Contract" to one of OMI's better contracts, the figures showing a decrease of 6.32 per cent in the number of "Standard Contracts" in force while all other contracts increased in percentage points.

These statistics show that the efforts being made constantly to have groups upgrade to better contracts are bringing results. The "Standard Contract" is no longer on the market for new subscribers. It will be written only when a group demands it at the time renewal of coverage in OMI is under consideration.

OMI will devote particular attention in 1965 to enrolling subscribers who do not have group affiliations, namely, individuals and members of their families. Also, it is planning to develop, in cooperation with the Blue Cross Plans of the state, a special contract geared to the needs of college and university students.

Report of the recent annual meeting of the

National Association of Blue Shield Plans was made by Ohio's delegates. The national organization adopted a resolution authorizing its board of directors to propose the services of Blue Shield in event a national medicare program is enacted. The action approving the proposal also endorsed a statement by the Reference Committee pointing out that it should be understood that Blue Shield Plans individually would, as they have in connection with all programs of national scope, make their own ultimate commitment to participate or not to participate on an individual plan basis.

A proposal that Blue Shield Plans not pay for the services rendered by interns and residents was defeated on the ground that this is a decision to be made by each individual plan.

### Nursing School Admissions Record High in 1964

Admissions to schools of nursing in the United States rose to an all time high of 92,300 students in 1964, Fred C. Foy, chairman, Committee on Careers, National League for Nursing, New York, announced. That figure represents an increase of 10,400, or 12.7 per cent, over 1963. The rise can be attributed in large part to the post World War II "baby boom," which is expected to bring 63 per cent more college students into higher education by 1975, Mr. Foy explained.

The most marked change in nursing was in admissions to the 1,158 programs of professional nursing. These reached an estimated 56,413 for the calendar year 1964, a breakthrough from the plateau level of 51,000 which has prevailed over the past few years. Of these, the largest number of new students, 38,986, were admitted to three-year diploma schools in hospitals. Second came 11,515 young men and women accepted by four-year baccalaureate programs in colleges and universities. The remaining 5,912 entered two-year junior or community college programs in nursing, which lead to an associate degree.

Admissions to schools of practical nursing continued the pattern of annual growth recently noted, rising from 30,585 in 1963 to an estimated 35,900 in 1964. There are 895 practical nursing programs.

To ascertain how estimated future needs might be met, the Committee on Careers sent a special questionnaire to all schools of nursing last year. Responses revealed that, with current facilities, professional programs had places for 6,293 additional students on December 15, 1964, and practical nursing, 2,769, or a total of 9,062 above the actual 92,300.

All categories of programs checked "insufficient qualified teachers" plus lack of clinical facilities and classroom space as main reasons for not being able to enroll even more students. Hospital schools also cited lack of dormitory space as a deciding factor. Other reasons included insufficient funds and inadequate qualifications on the part of applicants.

## Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

\* \* \*

Serendipity has always provided some of the greatest discoveries. Search for a seasickness remedy produced the antihistamines. Investigation of a hiccup remedy yielded a potent analgesic. Subsequently, the antihistamines were discovered to be antinauseants; then tranquilizers. Snake venoms, studied for the treatment of arthritis, were found to be anticoagulants and fungicides. The combined study of antibacterial drugs and cabbage feeding led to the antithyroid drugs. From these, it can be seen that the ultimate destiny of a new drug is not always predictable until its use is widespread. — A. Lee Lichtman, M. D., in *Experimental Medicine and Surgery*, 22:2-3, (June-Sep.) 1964.

\* \* \*

We have in a sense been caught by our own ingenuity. The day is past when we could say, as Oliver Wendell Holmes did, "Throw out opium . . . throw out a few specifics which our art did not discover . . . throw out wine . . . and I firmly believe that if the whole materia medica, as now used, could be sunk to the bottom of the sea it would be all the better for mankind — and all the worse for the fishes." We cannot afford to do without good, new drugs. We can no longer say, as did Hippocrates, ". . . as to diseases make a habit of two things — to help, or at least not to do harm." — Louis Lasagna, M. D., in *Perspectives in Biology and Medicine*, 7:4 (Summer) 1964.

\* \* \*

For an objective evaluation of drug toxicity, emphasis should be placed on the relative usefulness of a given drug as well as on its potential harmfulness. Even such benign and essential agents as oxygen or water may be harmful when used inadvisedly as therapeutic agents . . . Drugs of such established value as digitalis are potentially lethal when used in excess. It is thus apparent that the potential toxicity of drugs must be counterbalanced by emphasis on their proper usage. The physician should be ever cognizant of the potential dangers of his medications as well as of their efficacy, and balance the two in determining the desirability of taking the risk involved. He should not use amidopyrine to treat a headache, but should have no hesitation in risking its potential harm when he needs an antipyretic for a patient with leukemia. The glucocorticoids should not be used in most patients with rheumatoid arthritis, but should never be withheld from patients with pemphigus. — Arthur Grollman, M. D., in *Texas State Journal of Medicine*, 61:1, (Jan.) 1965.



# Officers and AMA Delegates Elected At the 1965 Annual Meeting

**D**R. HENRY A. CRAWFORD, of Cleveland, was installed as President of the Ohio State Medical Association at the 1965 Annual Meeting of the Association in Columbus, May 9-14, succeeding Dr. Robert E. Tschantz, Canton, who will continue to serve on the Council for another year as Immediate Past-President. Dr. Crawford was named President-Elect at the 1964 Annual Meeting, and was installed as President at the final session of the House of Delegates at this year's meeting.

Dr. Crawford is a past-president of the Academy of Medicine of Cleveland, and was first named to The Council of the OSMA in 1960 as Councilor of the Fifth District. A native of Nelsonville, he is a graduate of Ohio Wesleyan University and the Western Reserve University School of Medicine. He is a member of the American Medical Association, a diplomate of the American Board of Surgery and a Fellow of the American Proctologic Society.

Dr. Lawrence C. Meredith, of Oberlin, was named President-Elect, and will assume the Presidency at next year's Annual Meeting in Cleveland. Dr. Meredith has served five years on The Council of OSMA as Councilor of the Eleventh District.

Dr. Meredith is a native of Syracuse, N. Y., but lived for many years in Lorain County where his late father also practiced as a physician. Dr. Meredith graduated from Oberlin College and the Ohio State University College of Medicine. He is a member of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology. His practice is limited to the ear, nose and throat field.

Elected to succeed Dr. Meredith as Councilor of the Eleventh District is Dr. William R. Schultz, of Wooster, a practicing physician specializing in the field of ear, nose and throat work. Among statewide assignments, Dr. Schultz has served as chairman of the OSMA Committee on Hospital Relations.

Councilors re-elected for additional two-year terms are Dr. Theodore L. Light, Dayton, Second District; Dr. Robert N. Smith, Toledo, Fourth District; Dr. Edwin R. Westbrook, Warren, Sixth District; Dr. Robert C. Beardsley, Zanesville, Eighth District; and Dr. Richard L. Fulton, Columbus, Tenth District.

Councilors in the midst of two-year terms are Dr. Robert E. Howard, Cincinnati, First District; Dr. Frederick T. Merchant, Marion, Third District; Dr. P. John Robeck, Cleveland, Fifth District; Dr. Benjamin C. Diefenbach, Martins Ferry, Seventh District; and Dr. George N. Spears, Ironton, Ninth District. Dr. Philip B. Hardyman, Columbus, is serving a three-year term as Treasurer.

Dr. Frederick P. Osgood, Toledo, was elected a delegate to the American Medical Association. Re-elected delegates were Drs. Edwin H. Artman, Chillicothe; John H. Budd, Cleveland; Richard L. Meiling, Columbus, and Charles A. Sebastian, Cincinnati.

Holdover delegates are Drs. T. L. Light, Dayton; George W. Petznick, Cleveland; Carl A. Lincke, Carrollton; and Edmond K. Yantes, Wilmington.

Elected to succeed Dr. Osgood as an alternate delegate was Dr. Robert N. Smith, Toledo. Alternate delegates re-elected are Drs. Hardyman, Tschantz, Robeck and J. Robert Hudson, Cincinnati. Holdover alternates are Drs. H. T. Pease, Wadsworth; Robert S. Martin, Zanesville; Kenneth D. Arn, Dayton; and Harry K. Hines, Cincinnati.

Because of the time element, only this brief summary of the election is given. Detailed reports, including minutes of the House of Delegates, will be published in the July issue.

# REPORT ON EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 1964, OF OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL

## ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations  
Ohio State Medical Association  
Columbus, Ohio

We have examined the statement of assets of the Ohio State Medical Association at December 31, 1964, and the related statement of cash receipts and disbursements of the Executive Secretary and the Treasurer and the statement of operations of the Journal for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The accounts of the Executive Secretary and the Treasurer included in these statements are maintained on the cash receipts and disbursements basis. The accounts of the Journal included herein are presented on the accrual basis. In the accompanying financial statements, 1965 dues of \$86,422.50 received in 1964 are included as income. Under generally accepted accounting principles, these dues would be deferred and taken into income during 1965. Due to the materiality of this item, the statements as a whole do not present financial position and results of operations as they would appear had generally accepted accrual basis accounting principles been applied.

In our opinion, the data set forth in the accompanying statement of assets of the Ohio State Medical Association at December 31, 1964, and the related statement of cash receipts and disbursements and the statement of operations of the Journal for the year then ended have been fairly summarized on the basis indicated in the preceding paragraph and are consistent with similar data for the preceding year.

Columbus, Ohio  
March 19, 1965

Lybrand, Ross Bros. & Montgomery

### OHIO STATE MEDICAL ASSOCIATION Statement of Assets, December 31, 1964

	Total	Executive Secretary's Account	Treasurer's Account	The Journal
Cash in bank .....	\$120,918.47	\$ 87,429.03	\$ 31,108.57	\$ 2,380.87
Cash in savings accounts .....	72,868.72		72,868.72	
U.S. Government bonds, at cost .....	75,000.00		75,000.00	
Accounts receivable, advertisers .....	9,454.67			9,454.67
Deposits: postage and petty cash .....	190.00			190.00
Office equipment, at cost less accumulated depreciation of \$28,187.52 .....	18,267.74			18,267.74
	\$296,699.60	\$ 87,429.03	\$178,977.29	\$30,293.28



Ohio State Medical Association  
Statement of Cash Receipts and Disbursements, Year ended December 31, 1964

	Total	Executive Secretary's Account	Treasurer's Account
Cash in bank, beginning of year .....	\$103,074.06	\$ 74,246.51	\$ 28,827.55
<b>Cash receipts:</b>			
1965 membership dues .....	86,422.50	86,422.50	
1964 membership dues .....	258,502.50	258,502.50	
Interest on savings deposits .....	2,862.64	2,862.64	
Interest on U.S. Government bonds .....	1,552.01		1,552.01
Exhibit space, 1964 annual meeting .....	17,059.00		17,059.00
Exhibit space, 1965 annual meeting .....	7,595.00		7,595.00
Fees for collection of A.M.A. dues .....	3,660.30		3,660.30
Collection of loan to Ohio Medical Political Action Committee (includes \$400.00 interest) .....	10,400.00		10,400.00
Redemption of U.S. Treasury note .....	5,000.00		5,000.00
	<u>\$393,053.95</u>	<u>\$347,787.64</u>	<u>\$ 45,266.31</u>
Interaccount transfers (principally 1964 dues) .....		(334,605.12)	334,605.12
<b>Cash disbursements:</b>			
The Ohio State Medical Journal .....	42,000.00		42,000.00
Salaries and expenses (Staff, Officers and Council) .....	149,628.88		149,628.88
Professional conferences and scientific meetings ..	56,006.69		56,006.69
Committee expenses .....	13,307.81		13,307.81
Department of Public Relations .....	11,544.02		11,544.02
Employees' benefits .....	17,220.01		17,220.01
Contributions .....	7,660.30		7,660.30
General .....	55,222.70		55,222.70
U.S. Treasury bonds purchased .....	15,000.00		15,000.00
Loan to Ohio Medical Political Action Committee ..	10,000.00		10,000.00
	<u>\$377,590.41</u>		<u>\$377,590.41</u>
Cash in bank, end of year .....	<u>\$118,537.60</u>	<u>\$ 87,429.03</u>	<u>\$ 31,108.57</u>
Cash in savings accounts, beginning of year .....	\$ 69,851.01		\$ 69,851.01
Interest received .....	3,017.71		3,017.71
Cash in savings accounts, end of year .....	<u>\$ 72,868.72</u>		<u>\$ 72,868.72</u>

The Ohio State Medical Journal  
Statement of Operations, Year ended December 31, 1964

<b>Income:</b>		
Advertising, net .....	\$ 51,825.75	
Appropriation .....	42,000.00	
Other, miscellaneous .....	3,416.04	\$ 97,241.79
<b>Expenses:</b>		
Salaries .....	\$ 24,420.00	
Journal printing .....	62,017.70	
Other (includes depreciation of \$1,869.89) .....	9,059.09	\$ 95,496.79
<b>Net Income</b> .....		<u>\$ 1,745.00</u>

# Do You Know? . . .

Dr. Robert W. Kellermeyer, instructor in medicine at Western Reserve University School of Medicine, was appointed one of 25 designated Markle Scholars in Academic Medicine. Grants are for five years of academic study. In 18 years, the John and Mary R. Markle Foundation has aided 406 medical school faculty members through its program of scholarships.

\* \* \*

Dr. Joseph A. Quigley, Cincinnati, director of health and safety for the National Lead Company of Ohio, was elected to the board of directors of the Industrial Association at the organization's recent annual meeting in Bal Harbour, Florida.

\* \* \*

The Southwestern Ohio Society of Family Physicians presented one of its seminars at the Academy of Medicine of Cincinnati headquarters auditorium on April 25. The topic for discussion was Dermatology.

\* \* \*

Two Cincinnati physicians will play leading roles in editing a new journal for radiologists, *Seminars in Roentgenology*, to begin publication in January, 1966. Dr. Benjamin Felson, professor and head of the Radiology Department in the University of Cincinnati College of Medicine, will be editor, and Dr. Jerome F. Wiot, associate professor, will be assistant editor. Plans are for quarterly publication.

\* \* \*

Dr. Albert B. Sabin, producer of the oral polio vaccine that bears his name, recently was presented the Bavarian Order of Merit from the German Government. The award was presented on behalf of the prime minister of Bavaria by German Consul Werner von Holleben, of Cleveland, in ceremonies on the University of Cincinnati campus.

\* \* \*

The late Dr. Benjamin S. Park, Painesville, was honored when Board of Trustees of the Ohio Division of the American Cancer Society dedicated the minutes of its meeting to "stand as a memorial to his splendid and unselfish service."

\* \* \*

Three Cleveland physicians practicing together are taking turns serving tours on the hospital ship S. S. Hope, now in the port of Conakry, Guinea. They are Drs. George G. Goler, Bernard S. Abrams and Marvin Brown. Another Cleveland, Dr. Harvey Mendelsohn, recently served a tour on the ship.

\* \* \*

In an exchange educational program between the two hospitals, Dr. Warren W. Smith, of Riverside Methodist Hospital in Columbus, spoke to the staff of the Methodist Hospital of Indianapolis, Indiana, and Dr. Thomas E. Lunsford of Indianapolis spoke to the Columbus group.

## Payments under Health Insurance Reach All Time High for Year

Insurance companies paid out a total of \$2,326,000,000 in 1964 to insured persons to help them pay their hospital bills, the Health Insurance Institute reported.

That figure, the Institute said, represents an average of \$6.4 million a day. The companies' payments were made under hospital expense policies and under the portion of major medical expense programs which provide for hospital charges.

These benefits helped pay for hospital charges for room and board, drugs and medicines, laboratory services, x-rays, routine nursing, operating room and other hospital services.

Including health insurance payments for other than hospital care, insurance companies last year distributed total benefits of nearly \$4.7 billion, a 12.2 per cent climb over 1963.

For over two decades there has been continuous growth in the amount of hospital expense benefits paid by all insuring organizations, which, in addition to insurance companies, include Blue Cross, Blue Shield and similar health care plans. This growth, stated the Institute, can be shown by an analysis of hospital benefits paid during 1953 and 1963, the last year for which data from all insuring organizations are available.

In 1953, all insuring organizations combined paid a total of \$1,275,000,000 in hospital expense benefits. The figure climbed to \$4,554,000,000 in 1963 for an increase of 257 per cent, according to the Institute.

Over the same 1953-1963 period, the amount of hospital expense benefits paid out by insurance companies alone rose from \$540,000,000 to \$2,050,000,000, an increase of 280 per cent, said the Institute. Hospital expense benefits paid by Blue Cross, Blue Shield and all other health care plans rose over this span from \$735,000,000 to \$2,504,000,000, a boost of 241 per cent.

## Trauma Is Program Feature at Steubenville Meeting

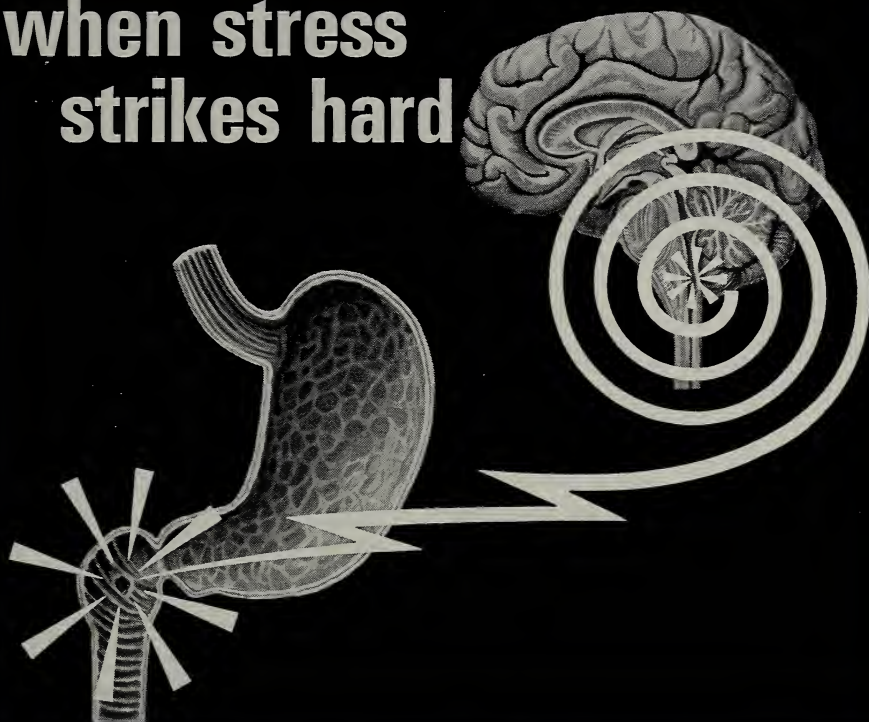
The local committee on Trauma of the American College of Surgeons co-sponsored a program with the Fort Steuben Academy of Medicine on May 11 in Steubenville.

The subject, "Thoracic and Abdominal Injuries," was discussed by a team from Pittsburgh, Pa., consisting of the following physicians: Drs. William B. Ford, James W. Giacobine, Emire Zekria, Murray Sachs and Theodore Morgan.

A demonstration on positive pressure pulmonary resuscitators was followed by a social hour and dinner at the Fort Steuben Hotel, after which the evening program was held.



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## M. D.'s in the News

Dr. Ford C. Ganyard, of Wooster, discussed "Mental Health" at a PTA meeting in the West Hill School of Rittman.

\* \* \*

Dr. Nissim Benado, Steubenville, was speaker at a meeting of the Toronto (Ohio) Parent-Teachers Association, where he discussed "Mental Health."

\* \* \*

Dr. Raymond L. Kercher, Medina, was speaker at the Medina County District Nurses Association which met at the Lodi Community Hospital. He discussed "Current Concepts of Immunization."

\* \* \*

Dr. Conrad K. Clippinger spoke on medical care at a meeting of the Della Robbia Grandmothers Club of Covington.

\* \* \*

Dr. S. E. Kerr, pathologist at Massillon City Hospital, gave an illustrated talk, relating his experiences on the S. S. Hope team before a meeting of the Women's Association of the Massillon Central Presbyterian Church.

\* \* \*

Dr. Harriet P. Dustan, member of the Research Division staff of Cleveland Clinic Foundation, spoke before the annual meeting of the Lake County Branch of the Heart Association of Northeastern Ohio.

\* \* \*

Dr. Joseph C. Jenkins spoke before a meeting of the Mentor Preschool PTA group on the subject, "Sibling Rivalry and Discipline."

\* \* \*

Dr. John J. Cahill, Willoughby, discussed "Chemotherapy in Cancer," before a meeting of the Northeastern Ohio Association of Medical Librarians.

\* \* \*

An article in the *Lima News* featured a warning by Dr. Robert S. Oyer, area health commissioner, for the public to beware of quackery offered by quasi-scientists.

\* \* \*

Dr. Arthur G. James, Columbus, was featured speaker in Cadiz at a kick-off meeting of the cancer campaign in Harrison County.

\* \* \*

Dr. Edgar C. Northrup, Marietta, gave an illustrated talk on "The Human Heart" before a group at the Norwood Methodist Church.

\* \* \*

Dr. Walter W. Lang, Kent, spoke on "The Genesis, Diagnosis and Treatment of PKU," at a meeting of the Council for the Retarded Child of Portage County.

## Sponsored Research Now Exceeds Regular Operating Programs In Medical Schools

Although regular operating expenditures of the nation's schools of medicine have nearly doubled since World War II, they have not increased as rapidly as expenditures for sponsored programs which have almost quadrupled in the same period, the Association of American Medical Colleges reported.

The report breaks down funds that medical schools receive into three categories: Regular operating programs, sponsored research programs, and other sponsored programs.

Regular operating program expenditures are made mainly from intramural funds of the medical school and university for support of the basic education program, and are under the control of the medical school and its sponsors. These funds include appropriations, endowment income, tuition, unrestricted gifts, and income derived by the school from some service functions.

Funds medical schools receive from extramural federal and non-federal sources are provided for research, training, and special programs. These funds are referred to as sponsored funds since the use of these funds is designated by the sponsor and they must be spent in compliance with the sponsor's restrictions.

All sponsored program expenditures have shown an average annual increase of 20 per cent in the period 1956-57 to 1962-63. The proportion of total medical school expenditures allocated to sponsored programs has increased from 39 per cent to 58 per cent. Expenditures from such restricted funds are divided between "sponsored research programs" and "other sponsored programs." "Other sponsored programs" support selected teaching and training projects, mostly research training.

Sponsored research programs, while expanding at close to the same rate as other sponsored programs, now account for the largest annual dollar expenditure in the schools of medicine.

The report shows that regular operating programs increased from \$146 million for the academic year 1956-1957 to \$256 million for 1962-1963. The latter amount is 42 per cent of the medical school dollar.

Sponsored research program funds increased from \$74 million in 1956-1957 to \$264 million in 1962-1963. The \$264 million was 44 per cent of medical school expenditures.

Other sponsored programs rose from \$18 million at the start of the period to \$82 million; comprising 14 per cent of the school dollar at the end of the period.





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## Capital Improvements Program Set In Motion with Approval of Ohio Voters on May 3

Immediately following the election on May 3, Governor James A. Rhodes announced that he was setting matters in motion to implement the capital improvements bond issue and other issues approved by the voters.

Issue No. 2, or the \$290 Million Bond Issue, authorizes the financing of higher education, health department facilities, emergency public school building aid, park and recreation improvements, prisons, pipelines, airports, historical facilities and other public works. Interest on the bonds is to be paid from the State's General Revenue funds.

The issue provides approximately \$7.5 million to start construction on the newly authorized Toledo Medical School. Recommended by the Ohio Board of Regents, the Toledo State College of Medicine was authorized by the recent special session of the Ohio General Assembly, to be established in connection with the University of Toledo.

Governor Rhodes authorized State Health Director, Dr. Emmett W. Arnold to proceed with plans for a modern health laboratory. Under the bond issue, approximately \$5 million is earmarked for a new State Health Department building and laboratory. Approximately \$1 million also is available from matching federal funds for this purpose.

Another \$8 million of the issue is earmarked for construction of new juvenile institutions, and the Ohio Youth Commission has been directed to proceed with recommendations in this respect.

The Governor also directed Mental Hygiene and Correction Director Martin A. Janis to complete plans for abandoning the antiquated Ohio Penitentiary in Columbus and recommend arrangements for a new maximum security prison.

Governor Rhodes further called upon the Ohio Board of Regents to implement an expanded higher education program, now totaling \$320 million in capital investments. The new bond issue calls for \$145 million for research and development, technical institutes and community colleges.

Under Issue No. 1, the voters backed up the State's program through which loans to assist Ohio college students are guaranteed. Student financial aid was authorized by the Ohio General Assembly in 1961. Issue No. 1 clears up any doubt as to constitutionality of the program. The Ohio Higher Education Assistance Commission is designated to administer the program.

Under Issue No. 4, the voters put back into motion the Industrial Development program previously sponsored by Governor Rhodes. The program provides an industrial development financing program to en-

## Narcotics Registration Must Be Renewed by July 1

On or before July 1, every physician registered under the Harrison Narcotic Act, must (unless he is in military service) re-register with the Director of Internal Revenue of the District in which he maintains an office and pay the Federal Narcotic Tax of \$1. Initial application may be made at any time, but existing permits must be renewed on or before July 1, annually.

Registration forms are mailed each year by the Narcotics Division to physicians on record. But the physician is responsible for re-registering whether or not he receives a form. A penalty is incurred by those who fail to re-register before deadline. Gross violations of the Narcotic Act are punishable by heavy fines and imprisonment.

Physicians who administer, dispense or prescribe cannabis must obtain a special permit under the Marihuana Tax Act and pay an additional tax of \$1.

courage new and expanded industry in Ohio primarily through self-liquidated loans.

## Reapportionment Plan Defeated

Issue No. 3, which went down to defeat in the election, was put on the ballot as the result of House Joint Resolution 1 passed during the Special Session of the Ohio General Assembly. Provisions of the proposed amendment to the Ohio Constitution was explained in the February issue of *The Journal*, beginning on page 161.

A ruling of the U. S. Supreme Court invalidated the "Hanna Amendment" in the Ohio Constitution, which guaranteed to each county, regardless of population, at least one member in the Ohio House of Representatives. The proposed amendment was considered by its proponents as a means of complying with the U. S. Supreme Court ruling, which gives Ohio until the end of 1965 to devise a plan.

The Ohio General Assembly now has the reapportionment program under consideration. Under the federal court's mandate of "one man - one vote," the Legislature may come up with a new proposal for voters in November, or reapportionment may be left up to the federal courts to decide.

The Fort Steuben Academy of Medicine had as guest speaker on April 13 Dr. Victor C. De Luccia, of New York City, who spoke on "The Physiological Aspects of Chest Trauma." The dinner meeting was held in the Fort Steuben Hotel, Steubenville.



# Ad Astra

**Edward Joseph Amberg, M.D.,** Cincinnati; St. Louis University School of Medicine, 1931; aged 60; died April 21; member of the Ohio State Medical Association, the American Medical Association and the Industrial Medical Association. Dr. Amberg was engaged in general practice in the Toledo area until 1950 when he moved to Cincinnati and became physician for the Pennsylvania Railroad. Survivors include his widow, a daughter, two sons, and three sisters.

**Francis Hamilton Beckstead, M.D.,** Nephi, Utah; Western Reserve University School of Medicine, 1920; aged 74; died October 28. Educated in Ohio, Dr. Beckstead practiced in the Utah community for many years.

**Roy G. Conrad, M.D.,** Weirton, W. Va.; Jefferson Medical College of Philadelphia, 1936; aged 54; died April 25. A practicing physician and surgeon in the West Virginia community since 1955, Dr. Conrad also practiced in the bordering areas of Ohio.

**Harold Riemann Davidson, M.D.,** Cleveland; Western Reserve University School of Medicine, 1920; aged 76; died April 16; former member of the Ohio State Medical Association. A practicing physician for many years in the Cleveland area, Dr. Davidson was one of a family of physicians in the area. He is survived by a brother and a sister.

**William Dreyfuss, M.D.,** Cleveland; University of Freiburg, Germany, 1924; aged 66; died April 30; member of the Ohio State Medical Association, the American Medical Association, and the American Urological Association; Fellow of the American College of Surgeons. Educated in Germany, Dr. Dreyfuss had been a practicing physician and surgeon in the Cleveland area since 1927. During World War II, he served in the U.S. Army Medical Reserve Corps. Surviving are his widow and a son, Dr. Michael Dreyfuss, also a physician.

**Albert Kreider Howell, M.D.,** Springfield; Ohio State University College of Medicine, 1925; aged 65; died April 24; member of the Ohio State Medical Association, the American Medical Association, and the American College of Obstetricians and Gynecologists. A native of Miami County, Dr. Howell took his internship in Springfield and practiced there for some 40 years. He was twice president of the Clark County Medical Society. Other interests included business and sporting groups. A veteran of World War I, he was a member of the American Legion and

the Disabled Officers Association. Other affiliations included memberships in several Masonic bodies and the Methodist Church. Dr. Howell is survived by his widow and two daughters.

**Gilbert D. Keil, M.D.,** Toledo; Ohio State University College of Medicine, 1939; aged 50; died April 12; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Born in nearby Woodville, Dr. Keil lived most of his life in the Toledo area where he practiced for about 25 years. He was a past-president of the Academy of General Practice of Toledo and Lucas County; was a member of the EUB Church and the Inverness Club. Surviving are his widow, two daughters and his parents.

**Hobart Ludlow Mikesell, M.D.,** West Liberty; University of Cincinnati College of Medicine, 1925; aged 67; died April 13; member of the Ohio State Medical Association, and the American Diabetes Association. A native of west-central Ohio, Dr. Mikesell devoted most of his professional career to practice in the Lorain County community. He was a veteran of both World Wars and attained the rank of lieutenant colonel during World War II. He was associated also with the American Legion and with the National Guard. Other affiliations included memberships in the Methodist Church, the Masonic Lodge and the American Red Cross. Surviving are his widow, two daughters, three half-brothers and a half-sister.

**Richard Marion Nelson, M.D.,** Cleveland; Medical College of Georgia, 1950; aged 48; died April 18; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology. A practitioner specializing in psychiatry in Greater Cleveland's East Side, Dr. Nelson was vice-president of the medical staff at the Windsor Hospital in Chagrin Falls. A veteran of World War II, he served as a lieutenant commander in the Navy. Survivors include his widow, three sons, three daughters and a sister.

**Gustav Selbach, M.D.,** Zanesville; University of Giessen, Germany, 1921; aged 68; died April 16; member of the Ohio State Medical Association; the American Medical Association and the American Society of Clinical Pathologists. Pathologist at Zanesville hospitals for only a short time, Dr. Selbach previously

was associated with hospitals in Wheeling, W. Va., and in New York State. Survivors include his widow and his son, Dr. Gustav J. Selbach, also of Zanesville.

**Aultman Baxter Shelton, M. D.,** Manchester; Eclectic Medical College, Cincinnati, 1926; aged 63; died April 7; member of the Ohio State Medical Association and the American Medical Association. A native of Adams County, Dr. Shelton practiced for some 31 years in Cincinnati. Following the loss of his sight in 1957, he undertook rehabilitation and in 1959 established a practice in Manchester. Affiliations included memberships in several Masonic bodies, and local Businessmen's, Kiwanis and Lions Clubs. Survivors include a son and two daughters by a former marriage; also his widow and his mother.

**John Herman Thesing, M. D.,** Cincinnati; Medical College of Ohio, Cincinnati, 1896; aged 91; died April 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Thesing celebrated his Golden Anniversary as a practitioner in the Cincinnati area in 1946, then continued to practice until about five years ago. Surviving are his widow, four sons and three daughters.

**Bert E. Tyler, M. D.,** Cleveland; Western Reserve University School of Medicine, 1904; aged 83; died April 29; former member of the Ohio State Medical Association. Dr. Tyler devoted virtually all of his professional career of some 61 years to general practice on Greater Cleveland's West Side. In addition to his professional associations, he was active in several Masonic bodies. His widow survives.

**Frank Joseph Vokoun, M. D.,** Cleveland; Western Reserve University School of Medicine, 1924; aged 65; died April 9; member of the Ohio State Medical Association and the American Medical Association. A Cleveland physician and surgeon for some 33 years, Dr. Vokoun served in the Army Medical Corps during World War II and attained the rank of lieutenant colonel. He was a member of the Military Order of World Wars and several fraternal groups. Surviving are his widow, two sons and a daughter.

**John R. Willoughby, Jr., M. D.,** Warren; Cornell University Medical College, 1942; aged 49; died April 11; member of the Ohio State Medical Association and the American Medical Association; fellow of the American College of Surgeons; diplomate of the American Board of Surgery. A resident of Warren for much of his life, Dr. Willoughby opened practice there after taking residency training in New York and at the Youngstown hospitals. In addition to professional affiliations, he was a member of the Methodist Church. Surviving are his father and mother, Dr. and Mrs. John R. Willoughby, Sr., and a brother, Dr. Robert J. Willoughby, all of Warren; also his widow and two sons.

## New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during April. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

<b>Butler</b>	Richard S. Moraites, Cincinnati
William J. Crawford, Middletown	Carolyn Janet Newman, Cincinnati
<b>Clark</b>	Irwin C. Rosen, Cincinnati
Henry A. Diederichs, Springfield	Jean Catherine Stiens, Cincinnati
<b>Cuyahoga</b>	<b>Jefferson</b>
Norman A. Clemens, Cleveland	Otto Vogel, Richmond
George A. Hady, Cleveland	<b>Lucas</b>
Stratton W. Harrison, Cleveland	Alcuin Bennett, Toledo
Earl L. Orr, Cleveland	Donald A. Doneff, Toledo
Robert S. Ort, Cleveland	John A. Pigott, Toledo
George Rusyn, Cleveland	<b>Montgomery</b>
Frederic M. Stoller, Cleveland	Dwight T. Tuuri, Dayton
Vlasta Vyroubal, Cleveland	<b>Muskingum</b>
<b>Franklin</b>	Gustav Selbach, Sr., Zanesville
Dorsey Lee Gilliam, Westerville	<b>Summit</b>
<b>Hamilton</b>	Thomas M. Schluter, Akron
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# Activities of County Societies . . .

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### BUTLER

The Butler County Medical Society presented its second biennial conference on the Medical Aspects of School Age Athletics on April 21 at the Hamilton Elks Club.

\* \* \*

The Society held its regular monthly meeting at the Hamilton Elks Club on April 28. "Youth and Education" was the theme of the program and featured two Butler County educators, Dr. Lester L. Dickey, superintendent of Hamilton Public Schools, and James W. Grimm, supervisor of physical education and director of health services for the Hamilton Public Schools.

### HAMILTON

Program speaker for the April 13 meeting of the Academy of Medicine of Cincinnati was Dr. Janet McArthur, Vincent Memorial Hospital, Boston, whose topic was "Practical Endocrinology in the Female Patient."

## Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

### MONTGOMERY

At a recent meeting members of the Montgomery County Medical Society passed the following resolution: "Resolved, That a \$50.00 per capita voluntary contribution be made by active members of the Montgomery County Medical Society and that funds derived from such contributions be used (1) to promote what the Society considers to be sound and adequate health care plans for the over-65 group who need assistance and (2) to oppose those plans which the Society considers unsound and inadequate."

## Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

### LUCAS

The schedule of the Academy of Medicine of Toledo and Lucas County for April contained the following features:

April 2, General Section — Presentation of papers by residents of Toledo Hospitals. Awards given by the Maumee Valley Hospital Medical Advancement Trust Fund.

April 9 — "Steps Toward the Development of a Medical Center in Toledo," was topic discussed by a panel.

April 22 — Toledo Medical Library Association annual meeting at the Academy building, with a social hour, dinner and a program.

April 29-30 — Postgraduate Lecture Series; Theme: "Recent Developments in Surgical Treatment of Cancer and Vascular Disease"; guest speaker, Dr. Oscar Creech, Jr., Tulane University Medical School, New Orleans.

## Fifth District

(COUNCILOR: P. JOHN ROBECHKE, M. D., CLEVELAND)

### CUYAHOGA

"Reasons for Continuing Dialogue Between Doctor and Clergyman," was the topic of discussion for the April 21 meeting of the Academy of Medicine of Cleveland and Cuyahoga County. Program speaker was Dr. Thomas W. Klink, a clergyman and director of the religion-psychiatry division of the Menninger Foundation and Hospital, Topeka, Kansas.

### GEAUGA

"A Newspaperman's View of the Medical Profession" was the subject of an informal address delivered

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by Lawrence E. Gerrety, manager of *The Geauga Times Leader*, at a dinner meeting of the Geauga County Medical Society, April 9.

In a question and answer session after the address, much attention was given to steps that might be taken to improve the group's public relations and to establish a more accurate public image of the role of the Medical Doctor in community affairs. — *Gauga Times Leader*.

## Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

### MAHONING

During the month of April, the Mahoning County Medical Society launched a Pap Smear Campaign that will continue through the remainder of the year. In addition to radio, television, and newspaper publicity, the Medical Society provided cards for doctors' offices and for all workers in the Mahoning County Cancer Campaign, which publicized the Pap Smear Campaign and encouraged women to arrange for a test.

The hospital laboratories are cooperating in the campaign and will process slides without charge for indigent patients. No woman will be refused the test because she cannot afford to pay.

Chairman of the Cancer Committee of the Medical Society, which is conducting the Pap Smear Campaign, is Dr. S. W. Chiasson.

\* \* \*

David L. Babson, well-known investment counselor, was the speaker at the April 20 meeting of the Mahoning County Medical Society. Mr. Babson spoke on the topic, "Should Doctors Buy Common Stocks?" This was the second of a series of meetings devoted to economic subjects. In February, Clayton Scroggins discussed office management.

In the business portion of the meeting, Dr. Jack Schreiber introduced a non-participation resolution.

Those members present unanimously approved the intent of the resolution and voted that it be brought to the House of Delegates of the Ohio State Medical Association.

Dr. John J. McDonough, president, presided. Mr. Babson was introduced by Dr. J. W. Tandatnick, program chairman.

### SUMMIT

The topic, "Tax Exempt Deposits for Physicians in Retirement Funds," was discussed at the April 6 meeting of the Summit County Medical Society meeting in the Children's Hospital, Akron. Speakers included James Novak, general counsel for the Northwestern National Life Insurance Company, Milwaukee, Wisconsin, and John J. Delangrange, auditor for the Summit County Medical Society.

## Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D., MARTINS FERRY)

### BELMONT

Dr. Robert J. Izant, director of the Division of Pediatric Surgery, University Hospitals, Cleveland, was guest speaker at the April 15 meeting of the Belmont County Medical Society held at the Belmont

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Vitamin B <sub>6</sub> (Pyridoxine HCl)	2 mg.
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Hills Country Club. His subject was "Current Problems in Malignant Diseases of Children."

### Ninth District

(COUNCILOR: GEORGE NEWTON SPEARS, IRONTON)

#### LAWRENCE

A joint dinner and social meeting was held Friday evening (April 23) by the Lawrence County Bar Association and the Lawrence County Medical Society in the Patio.

Municipal Court Judge Lloyd Burwell, president of the Bar Association, presided. A brief talk was given by Attorney Larry Morris.

Twelve members of the Bar Association and six physicians were present. — *Ironton Tribune*.

### Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

#### LORAIN

Record interest was shown in the 18th Annual Medical Symposium held at Oberlin Inn, the afternoon and evening of April 14. Arranged for by Lorain County Medical Society Vice-president, Max L. Durfee, M. D., it dealt with "Acute and Chronic Respiratory Disease," and the participants included:

J. Arthur Myers, M. D., emeritus professor of public health at the University of Minnesota, and the editor in chief of *Diseases of the Chest*.

Joseph B. Stocklen, M. D., controller of tuberculosis in Cuyahoga County.

Myron M. Perlich, M. D., assistant controller of tuberculosis in Cuyahoga County and assistant clinical professor of medicine at Western Reserve University.

Melvin S. Rosenthal, M. D., assistant professor of preventive medicine at Western Reserve University.

David G. Gillespie, M. D., assistant professor of medicine at Western Reserve University, and with pulmonary disease service at Cleveland Metropolitan General Hospital.

Peter J. Ferrato, M. D., Fellow of American College of Chest Physicians, practicing his specialty of thoracic surgery and cardiovascular disease in Lorain County.

Seventy-four physicians took advantage of this opportunity, including representatives from other counties in the Eleventh District, osteopathic physicians on medical staffs of Lorain County hospitals and interns and residents of St. Joseph and Elyria Memorial Hospitals.

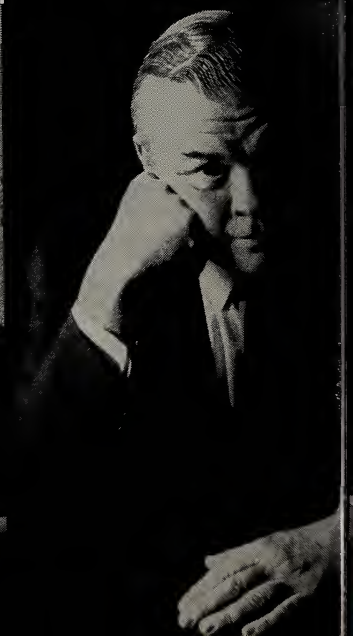
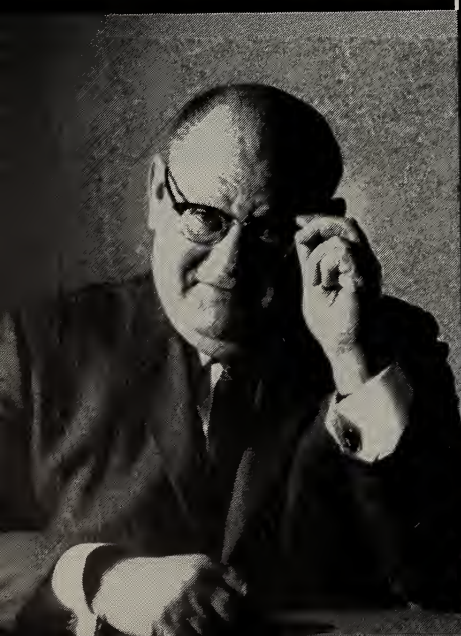
The special program arranged for physicians' wives during the afternoon was enthusiastically received,

## in the overweight stable adult

...fasting serum levels of insulin are usually normal, postprandial levels excessive<sup>1,3</sup>

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat<sup>1,4</sup>

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain<sup>1,3,4</sup>





and contributed much to the event. In all, 110 persons were present, making this the largest attendance at the Medical Symposium to date.

Following the Social Hour and dinner, president John W. Wherry conducted a brief business meeting. In presenting those seated at the head table, Dr. Wherry invited immediate past-president of Ohio State Medical Association, and previous Councilor of the Eleventh District, Horatio T. Pease, M. D., to speak.

The present Eleventh District Councilor, L. C. Meredith, M. D., urged attendance at OSM Annual Meeting, and continued activity in writing Senators with reference to Medicare Bill.

Shan Asad Mohammed, M. D., was unanimously elected to Associate Membership in Lorain County Medical Society.

The Symposium concluded with an outstanding lecture by Dr. Myers, challenging all to work for eradication of tuberculosis.

#### RICHLAND

The Richland County Medical Society sponsored an exhibit at the fourth annual convention of the Ohio Genealogical Society in Mansfield, May 2-3. Immunization progress in the past 70 years was depicted in the display.

### WHAT TO WRITE FOR

Health Publications from the Pharmaceutical Industry. A catalog of some 130 publications produced by pharmaceutical companies on such subjects as disease prevention, health careers, drug discoveries, etc., most of them free for the asking. Public Information Office, Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N. W., Washington, D. C. 20005.

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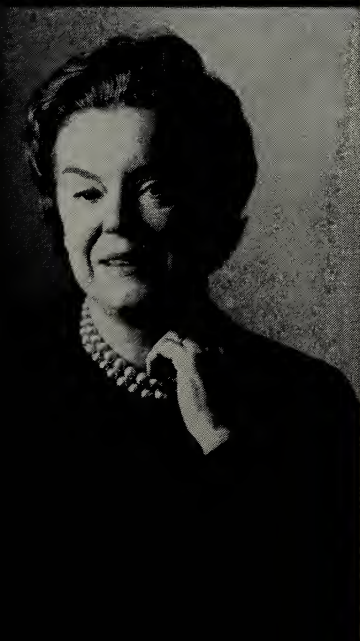
Acute Conditions — Incidence and Associated Disability — United States, July 1963 - June 1964. Statistical data contained in Public Health Service Publication No. 1000 - Series 10 - No. 15; for sale by Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 40 cents.

\* \* \*

Demographic Characteristics of Persons Married Between January, 1955 and June, 1958. Statistical data contained in Public Health Service Publication No. 1000 - Series 21 - No. 2; for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402; price 40 cents.

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1. Gordon, E. S.: Metabolism 11:819, 1962. 2. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 3. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 6. Faludi, G.: Geriatrics 18:452, 1963. 7. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. 8. Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. 9. Moss, J. M. et al.: Med. Times, July 1964.

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# Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Publicity Committee  
Chairman, 2442 Dorman Dr., Portsmouth

ARE YOU "New York-bound" this month? Then these gracious words are meant for you and are uttered by our national president, Mrs. William H. Evans: "A cordial invitation is extended to all members, their guests, the wives of AMA delegates and alternates, the wives of AMA international guests, and guests of physicians attending the AMA convention, to participate in all social functions and to attend the general meetings of the Auxiliary" . . . To recap (from last month's column) — the forty-second annual convention will be held between June 20 and 24 at the Americana Hotel, 52nd Street and 7th Avenue, New York City.

Of particular interest to those of you who are bringing your children along is the tremendously worthwhile and entertaining pre-teen and teen-age convention program. The schedule covers everything from NBC-TV and Empire State Building tours to the World's Fair; from the Bronx Zoo to Coney Island; from a "Little Old New York" gad-about (including a Boat Ride around Manhattan with lunch aboard) to two gala evening programs on Monday and Wednesday nights.

Reservations must be made directly with Gulliver's Trails, 25 Central Park West, New York, New York 10023. A check must be enclosed to confirm the reservations. (Monday and Tuesday programs are combined, cannot be taken separately: cost \$21.95. Wednesday, Thursday and Friday trips are \$10 each. All-inclusive price for any five trips is \$48.50. The Monday evening dinner and Broadway film for pre-teens: \$10; the gala evening at the World's Fair that same night for teen-agers: \$12.50; Wednesday evening will find the pre-teens at the World's Fair: \$11.95; the teen-agers will be frolicking at Greenwich Village: dinner and two shows in top teen-age clubs: \$11.50). Youngsters aged eleven or twelve who would prefer participating in the teen-age program will be permitted to do so.

## From Here and There

The Allen County Auxiliary hosted a covered dish luncheon at the home of Mrs. Thomas D. Allison, Wapakoneta. Travelogue slides were shown by Mrs. H. C. Weisenbarger who had made a round-the-world trip, and by Mrs. C. H. Zinsmeister who had toured Africa and Europe. The hostess committee was under the chairmanship of Mrs. R. R. Snowball.

The Erie County group held its April meeting at the home of Mrs. Malcolm Boylan. Mrs. Boylan was appointed chairman of the nominating commit-

tee with Mrs. Joachim Gfoeller and Mrs. Dean Sheldon named to serve with her. A letter of appreciation was read from the superintendent of elementary education, thanking the group for its assistance in the hearing test programs in Sandusky schools. Hostesses for the meeting included Mrs. Sheldon, chairman; Mrs. H. B. Janssen, Mrs. T. H. Smith and Mrs. P. F. Southwick.

The April meeting of the Fairfield County Auxiliary was a luncheon at the home of Mrs. William Jasper. The hostess committee included Mrs. Jack Kraker, Mrs. George Mogil, Mrs. Fred Spangler and Mrs. Frederick James. Brief reports were given by Mrs. Jasper on Paramedical Careers and by Mrs. Spangler on activities at the Cerebral Palsy Center. Fifteen boxes of sample drugs collected by Fairfield members were packed and readied for transportation to the World Medical Relief Warehouse through the courtesy of the Gaffney Motor Freight Company. Mrs. Gordon Snider, program chairman, introduced the guest speaker, Mr. E. R. Lantz, local attorney, who presented a "Financial Roadmap for Doctors' Wives."

Mrs. Edward Gretchen was installed as president of the Hancock Auxiliary at a luncheon held at the Williams Country Club in April. She succeeds Mrs. Leonard Yurko. Mrs. Ray S. Greco was installed as secretary and Mrs. George Kosar as treasurer. Mrs. Theodore Whitaker was the installation officer and hostess.

## Television and Health Careers

Hamilton County's president, Mrs. John B. Toepfer, was a member of the panel on an hour-long television program on the Health Careers Association of Greater Cincinnati. The activities of health careers clubs in the high schools were reviewed and discussed. (Medical auxiliary members serve as advisors to these groups.) The program was one of a series of Sunday morning telecasts "Call The Doctor" in which a panel of physicians answers questions telephoned to the studio by the viewing audience. Auxiliary members staff the telephones each Sunday and relay the questions to the panel moderator. . . . The officers and board of the Hamilton group entertained sixty-seven new members at an April tea at the Academy of Medicine. Committee chairmen described the various projects in a brief orientation program.

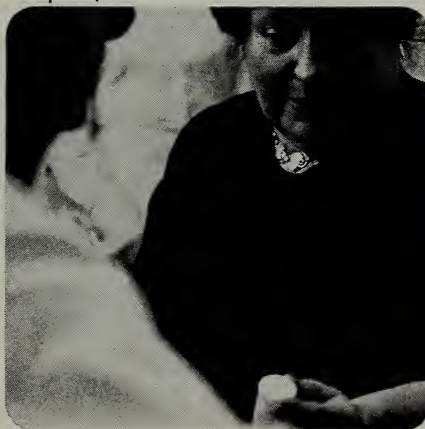
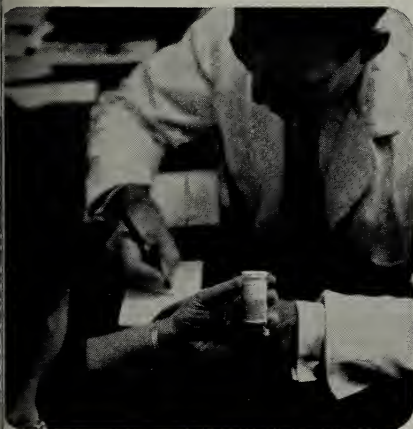
The Huron County group recently elected its new officers for the coming Auxiliary year at a meeting





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severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

**Side Effects:** Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

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\*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14-19, 1964.

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at the home of Mrs. John Rosso. These new officers are: Mrs. Earl McLoney, president; Mrs. Robert Higgins, president-elect; Mrs. John Blackwood, vice-president; Mrs. Rosso, secretary; Mrs. Charles Edel, treasurer. . . . Mrs. Jacob Mervis entertained members of the Jefferson County Auxiliary at an April luncheon at her home. Wives of local hospital resident physicians were also guests. Mrs. Harry Haverland was chairman of the meeting, assisted by Mrs. Lester Stein, Mrs. Max Rosenblum, Mrs. D. A. Macedonia and Mrs. Ernest Perri.

### Medicine and Religion

A provocative and significant symposium was presented by the Mahoning County Auxiliary at its April luncheon meeting at the Mural Room. "Medicine and Religion" (as applied to the female patient) was the subject of the panel discussion moderated by Dr. Frederick L. Schellhase and participated in by both physicians and clergymen. Serving on the physicians' panel were Dr. William Cleary, Dr. Leon Bernstein and Dr. William H. Bunn, Jr. Clergymen taking part included Dr. Sidney Berkowitz, Rev. Cyril Adamko and Rev. Samuel Sharp. Dr. John J. McDonough, president of the Mahoning Medical Society, was a guest speaker.

Invited to the symposium were hospital auxiliaries, the Corydon Palmer Dental Society, Podiatrists Association, Engineers Society, Architects Association, the Bar Association and several religious and social organizations. Specific case histories were presented and discussed. Certainly this type of program is a particularly outstanding one for an Auxiliary to sponsor (take note, you other Auxiliaries!). Medicine and Religion must work together if there is to be a truly effective and beneficial result for the frustrated, confused patient who cries hysterically "Why me? Why did it happen to me?" Mrs. Joseph Tandatnick, Auxiliary president, presided at the special meeting. Program chairman was Mrs. Frank Inui and social chairmen were Mrs. Robert Wiltsie and Mrs. A. William Geordan.

April was a busy month for the Mahoning group! The women also sponsored a Health Careers Day at South Side Hospital (the annual tours are conducted alternately at each of the area hospitals). Junior and senior high school students toured the hospital and later had an opportunity to meet and talk with representatives from each of the various health career fields. Co-chairmen for the Health Careers Day were Mrs. J. B. Stechschulte, Mrs. Henry Holden, Mrs. Henry Sisek, and Mrs. H. Paul Bauer, Jr. Mrs. Frank Gambrel heads the Health Careers Committee.

### "Baby Sitters" Trained!

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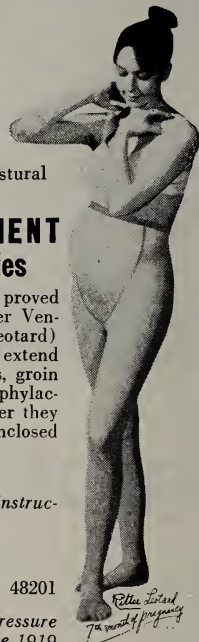
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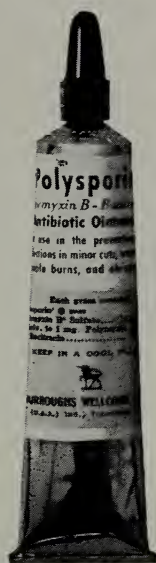
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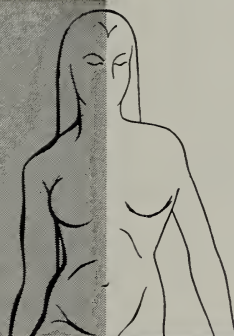


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sorship of the doctors' wives' groups. The idea for such an intensive course (there had been other attempts at such a program) was sparked by Mrs. Alden B. Oakes, president-elect. The girls who completed the training are members of Cadette Girl Scout Troops and credit for the course goes toward their "Requirement of Child Care" badge. Mrs. William E. Daehler served as chairman of the training program that included:

Lectures and demonstrations on care and feeding of small children and infants by Mrs. Mary Huels, supervisor of pediatrics at Mercy Hospital; "What-To-Do-in-an-Emergency" by Dr. Jack D. MacDonald, pediatrician, and Mrs. Daehler; instruction on the proper use of the telephone by Mr. A. U. Kauffman and Mrs. Margaret Campbell of the General Telephone Company; fire prevention and emergency training (including mouth-to-mouth resuscitation) by Lt. Marvin Triggs of the Fire Department; the question of ethics and the entertainment of children by Mrs. Daehler. A test concluded the carefully planned program. Here is something else that local Auxiliaries all over the state should be doing . . . (over and over again!).

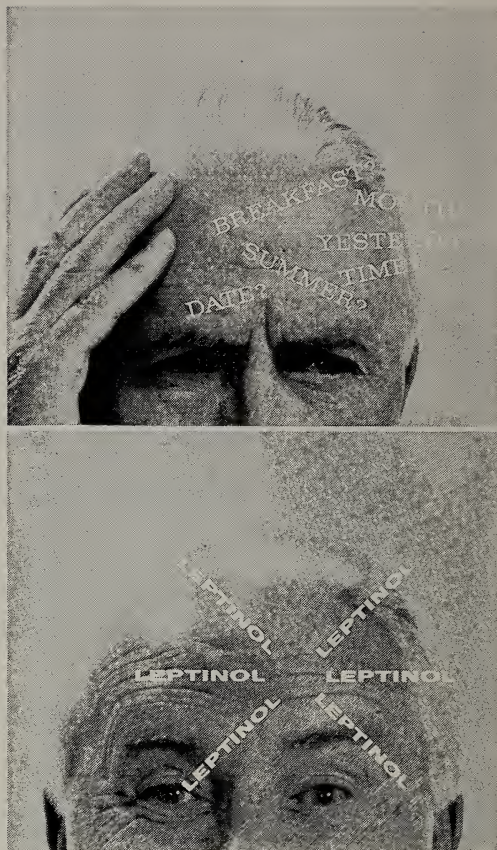
The Scioto County group entertained members of the Senior Citizens Club in April at a dessert luncheon at Mercy Hospital's Madonna Hall. Clay High School's debating team presented a lively forty-five minutes on the question of nuclear disarmament. Old and new folk songs were sung by Hilda and Clyde Fenton who played their own accompaniment on the banjo and guitar. Mrs. Clyde M. Fitch was chairman of this annual entertainment for Senior Citizens.

#### In Tuscarawas

"Home" of our new state president—Mrs. Herbert F. VanEpps . . . Dr. C. M. Dougherty, New Philadelphia surgeon, was guest speaker at the April meeting of the Tuscarawas County Auxiliary held in the auditorium of Union Hospital. Dr. Dougherty, a member of the Traffic Safety Committee of OSMA, spoke on the functions and activities of his committee and stated that water traffic had been added to the safety program. He introduced Corporal James Duncan of the State Highway Patrol who showed a film "Tragedy on Wheels" and answered questions on safety driving.

Mrs. E. R. Hammersley presided over the short business session. During a social hour, buffet refreshments were served from a table centered with pink carnations. Serving on the committee for this meeting were Mrs. C. J. Miller, Mrs. H. E. Reed, Mrs. J. W. Hamilton, Mrs. R. J. Foster and Mrs. G. S. Tripathy.

Dr. S. E. Kerr, of North Lawrence, showed slides and discussed his experiences aboard the hospital ship Hope last year in South America at a dinner meeting of the Navarre Kiwanis Club.



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2600 Union Central Bldg.

- ADAMS—Gary J. Greenlee, President, Farmers National Bank Bldg., Manchester; Stanley H. Title, Secretary, Seaman.
- BROWN—John A. Powell, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown. 3rd Sunday, monthly.
- BUTLER—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton. 4th Wednesday.
- CLERMONT—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.
- CLINTON—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p.m., monthly, Clinton Memorial Hospital.
- HAMILTON—John J. Cranley, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.
- HIGHLAND—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.
- WARREN—O. Willard Hoffman, President, 20 E. Fourth St., Franklin; Ray E. Simendinger, 901 Broadway St., Lebanon.

## Second District

Councilor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

- CHAMPAIGN—Isador Miller, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.
- CLARK—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.
- DARKE—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, 29 East Wood Street, Versailles. 3rd Tuesday, monthly.
- GREENE—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.
- MIAMI—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.
- MONTGOMERY—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.
- PREBLE—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.
- SHELBY—George J. Schroer, President, 322 Second Ave., Sidney; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney.

## Third District

Council: Frederick T. Merchant, Marion 43305  
1051 Harding Memorial Pky.

- ALLEN—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima. 3rd Tuesday, monthly, except June, July and August.
- AUGLAIZE—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville. Called meetings.
- CRAWFORD—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.
- HANCOCK—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.
- HARDIN—Glen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center. 2nd Tuesday, monthly, except June, July and August.
- LOGAN—Richard A. Firmin, President, Zanesfield; Ernest J. Henson, Secretary, 128 W. Baird St., West Liberty. 1st Friday, monthly.
- MARION—James A. McGlew, President, 399 E. Church St., Marion; Lester E. Wall, Secretary, 317 S. Main St., Marion. 1st Tuesday, monthly.
- MERCER—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.
- SENECA—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.

- VAN WERT—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.
- WYANDOT—Franklin M. Smith, President, E. Saffle Ave., Box 68, Sycamore; Robert E. Goynce, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

## Fourth District

Councilor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

- DEFIANCE—John W. Cullen, President, Box 218, Defiance; William S. Busted, Secretary, Box 218, Defiance. 1st Saturday, monthly.
- FULTON—Benjamin H. Reed, Jr., President, 101 Adrian St., Delta; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon. 2nd Tuesday, March, June, September and December.
- HENRY—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon. 1st Tuesday, monthly.
- LUCAS—R. Philip Whitehead, President, 424 W. Woodruff Ave., Toledo 43602; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday.
- OTTAWA—Robert Reeves, Port Clinton; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.
- PAULDING—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.
- PUTNAM—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Lugibihl, Secretary, Pandora. 1st Tuesday monthly.
- SANDUSKY—J. L. Zimmerman, President, Memorial Hospital, Fremont; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.
- WILLIAMS—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.
- WOOD—Louis P. Baldoni, President, 138 E. Front St., Perrysburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

## Fifth District

Councilor: P. John Robeck, Cleveland 44106  
10525 Carnegie Ave.

- ASHTABULA—Harmon O. Tidd, President, 362 Rogers Place, Ashtabula; William F. Doran, Secretary, 241 Mill St., Conneaut. 2nd Tuesday, monthly.
- CUYAHOGA—Middleton H. Lambright, Jr., President, 10616 Euclid Avenue, Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland, 6.
- GEAUGA—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanur Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.
- LAKE—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

## Sixth District

Councilor: Edwin R. Westbrook, Warren  
438 North Park Ave.

- COLUMBIANA—Peter Cibula, President, 356 E. Lincoln Way, Lisbon; Ernest P. Schaefer, Secretary, 190 Penn Ave., Salem. 3rd Tuesday, monthly.
- MAHONING—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.
- PORTAGE—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.
- STARK—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 44702. 2nd Thursday, monthly.
- SUMMIT—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.
- TRUMBULL—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

## Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry  
30 S. 4th St.

- BELMONT—Robert N. Lewis, President, 100 W. Main Street, St. Clairsville; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.



**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCOTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocoton. 2nd Tuesday, monthly.

**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.

**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

**MONROE**—Byron Gillespie, Secretary, S. Main St., Woodsfield.

**TUSCARAWAS**—S. H. Winston, President, 658 Boulevard, Dover; G. W. Johnston, Secretary, 658 Boulevard, Dover. 2nd Thursday, monthly.

## Eighth District

Councilor: Robert C. Beardsley, Zanesville  
2236 Maple Ave.

**ATHENS**—Robert E. Main, President, 400 East State Street, Athens; Lester A. Hamilton, Secretary, 400 East State Street, Athens. 2nd Tuesday at noon, monthly.

**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hodsden, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Senecaville; Doyle O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.

**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

**NOBLE**—F. M. Cox, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.

**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.

**WASHINGTON**—Donald Fleming, President, Vincent; Archbold M. Jones, Jr., Secretary, 326 Third St., Marietta.

## Ninth District

Councilor: George N. Spears, Ironton  
2213 S. 9th St.

**GALLIA**—Leonard Harris, President, Holzer Clinic, Gallipolis; James A. Kemp, Secretary, Holzer-Clinic, Gallipolis. Quarterly meetings at called times.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

**JACKSON**—A. R. Hambrick, President, Wellston; John C. MacLennan, Secretary, Oak Hill. Meeting date varies.

**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

**MEIGS**—Selim J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once monthly.

**PIKE**—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.

**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

## Tenth District

Councilor: Richard L. Fulton, Columbus 43212  
1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 266, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

**FAYETTE**—Thomas J. Hancock, President, 220 E. Market St., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 2nd Friday, monthly.

**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

**ROSS**—Paul F. MacCarter, President, 60 Central Center, Chillicothe; Robert L. Counts, Secretary, 56 E. Second St., Chillicothe.

**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

## Eleventh District

Councilor: William R. Schultz, Wooster  
1800 Beall Ave.

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Clem Chalfant, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.

**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P. O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

**HOLMES**—Owen F. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.

**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLony, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.

**MEDINA**—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Stanley L. Brody, President, 327 Park Ave. W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.



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The regular seminar of the Southwestern Ohio Society of Family Physicians was held on April 25 at the Academy of Medicine of Cincinnati auditorium where the subject of discussion was Dermatology.

Dr. Eugene Sherman, Mansfield discussed "Oral Contraceptives" at a meeting of professional nurses of District 5 in Mansfield.

Tuscarawas County doctors, members of the press and guests met at Union County Club, Dover, for the annual Doctors' Dinner given by the Tuscarawas County Heart Association.

## JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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Rates: 50 cents per line. Minimum charge of \$1.00 for each insertion. Prices cover the cost of remaining answers. Forms close 15th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal, 79 East State St., Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 79 E. State St., Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

**FOR RENT:** Office suite, New Medical Bldg. Modern; on one floor; parking space; air conditioned. Call 442-0106 (Cleveland).

**G. P. WANTED** at once to take over established practice of 41 years; excellent small town in Toledo area; fine hospitals; attractive opportunity. Box 363, c/o Ohio State Medical Journal.

**NEEDED — General Physician — Family Internist** by four man group in growing rural program in West Virginia. Modern clinic facilities, regularly visiting specialist consultant staff, scheduled training and vacation periods, foundation sponsorship, no investment required. Starting net income range \$14,000 - \$18,000 depending on qualifications. Box 383, c/o Ohio State Medical Journal.

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**GENERAL PRACTICE FOR SALE:** Modern office building with adjacent almost new 2-bedroom home in Bellefontaine. Open staff hospital. Leaving to specialize. Box 402, c/o Ohio State Medical Journal.

**GENERAL PRACTICE FOR SALE** near Columbus, Ohio, July, 1965. Modern Hospital with open staff. Attractive terms. Leaving to specialize. Box 404, c/o Ohio State Medical Journal.

**PSYCHIATRIC RESIDENCY AND STAFF POSITIONS** available — Appointments available at all levels for residency in three-year approved dynamic program in psychiatry. 2100-bed hospital with affiliated community service clinic, child psychiatry and psychosomatic medicine; individual and group psychotherapy under supervision of hospital staff and practicing psychiatrists in the community; organized didactic training in basic sciences, clinical neurology and psychiatry; hospital participates in visitors and exchange program; foreign graduates must be ECFMG certified; all Ohio Civil Service benefits including vacation, sick leave, retirement program; new pay scale effective January, 1965. Three years program: \$8,000-\$10,000 yearly; 5 years career program: \$11,000-\$16,000 yearly; those with 4 years private practice: \$12,000-\$14,000 annually. Staff psychiatrists wanted for positions paying from \$16,000 and up. Write: G. I. Podobnikar, M. D., Director, Education and Training, Columbus State Hospital, 1960 West Broad Street, Columbus, Ohio 43223.

**RURAL-SUBURBAN COMMUNITY** needs a General Physician. Will build a new Medical Center to doctor's specifications, with option to rent, lease, or buy. Within 10 miles from a new 96-bed hospital. Community of 2300 families in a growing area. New consolidated High School within 4 miles. Write Warsaw Lions Club, c/o Marvin Davis, Box 66, Warsaw, Ohio 43844. Phone 614-824-2421.

**PHYSICIAN** for large Eastern railroad; **ASSISTANT MEDICAL EXAMINER**; full time at Cincinnati, Ohio; vacation; work 8 hour day, 5 day week; fringe benefits. Box 416, c/o Ohio State Medical Journal.

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**G. P. WANTED, Aug. 1** to take over good practice. Excellent small town, DeGraff; near modern hospital in Bellefontaine. Attractive opportunity. Box 415, c/o Ohio State Medical Journal.

**PHYSICIAN WANTED.** Medical education director, full-time, salaried. Board certified or qualified. 350 bed general hospital. Please write, Administrator, St. John's Hospital, Cleveland, Ohio 44102.

**OB and GYN MAN** looking for association, group or clinic, or good location for private practice. Reply: Box 417, c/o Ohio State Medical Journal.

**WANTED: GENERAL PRACTITIONER.** Established practice near Toledo, Ohio, eight miles from hospital and university. Home, equipped office and financing available. Death reason for selling. L. R. McAdams, Ada, Ohio. Phone 634-3711.

**OFFICE FURNITURE FOR SALE:** Good condition. Columbus, telephone: 258-9556, Ext. 4.

**FOR SALE:** Picker X-Ray — Fluoroscope, Raytheon Microtherm and Beck-Lee Cardi-All EKG. Want to sell soon, as leaving to specialize. Michael Truman, M. D., 1070 Millville Ave., Hamilton, Ohio. Phone 895-4541.

**HELP! HELP! PHYSICIANS NEEDED.** One of Ohio's fastest growing and promising locations near new Dayton campus — (Extension "Ohio & Miami Universities"). Population to double by 1980. New addition to an already established building with a highly successful General Practitioner and Dentist. For information, write Don or Bob Morgan, 1711 E. 3rd Street, Dayton, Ohio. Better still, call collect. Area Code 513 — 254-3555. Evenings 513 — 426-0366.

**OHIO:** 12 years active general practice available in July. Beautiful suburban community of 5,000. One other physician; eight miles to good hospitals. New functional office, 1250 sq. feet. Nothing to buy unless equipment is desired. Rent \$150 monthly. Write or call collect. Miss Jo Denney, 322-1463 or 325-7651 c/o The Kissell Company, 30 Warder Street, Springfield, O.

**GENERAL PRACTICE FOR SALE OR RENT:** Office of deceased physician with full equipment, including x-ray, EKG, lab., instruments, etc. Excellent condition; community and surrounding area with population of approx. 5000. Will sell only equipment if interested. Dwight Pettay, Jr., 599 Dewey Ave., Cadiz, Ohio; phone 942-3100.

**CLINICAL DIRECTOR** of training and research, to assume responsibility for active on-going program with 18 residents in a 3-year program fully approved by A. B. P. & N. 2800-bed hospital accredited by J. C. A. H. Located in beautiful four season vacationland. Salary range \$18,437 to \$22,675, depending on qualifications. Requires minimum of certification and two years' experience. M. Duane Sommerness, M. D., Medical Superintendent, Traverse City State Hospital, Box C, Traverse City, Michigan.

**CHIEF OF SUPERVISORY STAFF** needed to help with clinical supervision and teaching in expanding (18 resident physicians) fully approved residency training program. Ideal living in active community in the heart of Michigan's Water Winter Wonderland. Newly established position requires board certification and additional experience in clinical supervision. Salary range depending upon qualifications, \$17,383 to \$21,339 with liberal fringe benefits. Arthur F. Dundon, M. D., Clinical Director, Traverse City State Hospital, Box C, Traverse City, Michigan.

**IDEAL LOCATION,** Dayton, Ohio: existing medical complex; 1000 sq. ft. remaining, adjacent Northtown Shopping Center, 4115 North Main Street. 300 car free parking. Call 275-5582; 275-4815.

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## Classified Advertisements (Contd.)

**FOR SALE.** Private island in Grand Lake, Alpena, Michigan. Completely equipped log cabin summer home on exclusive private island, with boats, furniture, all facilities, electric plant, and mainland docking property. Excellent fishing, swimming, and sailing on large lake. Island Associates, P. O. Box 414, Ann Arbor, Michigan.

**YOUNG GENERAL PRACTITIONER** with a well established, busy practice in a thriving rural community desires an associate. Jack L. Maffett, M. D., 264 S. Lisbon St., Carrollton, Ohio.

**CINCINNATI AREA — MARIEMONT:** Office for lease. This location has been a physician's office for 34 years. Near a very fine hospital. Write L. Hermanies, 3900 Oak St., Mariemont, Cincinnati, Ohio 45227. Telephone 271-0291.

**GENERAL PRACTITIONER.** Available immediately position for young G. P. in group practice. Group consists of two G. P.'s, an Internist and an American Board Surgeon, in new medical building with complete laboratory service and close to local hospital. Salary first year leading to partnership, no investment. Rural community, well located in central Ohio; excellent school system. Housing available. Some training in anesthesia helpful but not necessary. Reply Box 422, Ohio State Medical Journal.

**WANTED:** M. D., to cover busy emergency room during weekdays, surgical background desirable. Good income assured. Good potential in town over 100,000. Write: Sister M. Mercia, Administrator, Timken Mercy Hospital, Canton, Ohio 44708.

**WANTED:** An associate to share an excellent general practice in Northwestern Ohio. Some residency training in obstetrics or general surgery would be helpful. Box 381, c/o Ohio State Medical Journal.

**GENERAL PRACTITIONER** needed in Continental, Ohio: Present physician leaving; office and residence available; if desired, local Community Club will assist in building. Contact: Community Club, Don Myers, Continental News Review, Continental, Ohio.

**UNIVERSITY HEALTH SERVICE** — University of 13,500 is seeking service of qualified physician for full-time position on medical staff of Student Health Center. Present staff of six physicians being increased. Beginning salary \$13,000 plus excellent fringe benefits. Newly remodeled Center includes out-patient department, 90-bed hospital, full laboratory and physiotherapy departments, mental hygiene department, environmental health department and full staff of auxiliary personnel. Professional meetings and research encouraged but not required. Applicants will be contacted personally by director. Box 423, c/o Ohio State Medical Journal.

### Western Reserve Building Program Is Now Ahead of Schedule

The \$10,000,000 Robert H. Bishop, Jr., Building, the first building in the \$54,800,000 University Medical Center Development Program in Cleveland to be constructed, will be completed during the summer of 1966, almost one year ahead of schedule, director of University Hospitals Stanley A. Ferguson announced recently.

The advancement of the completion date of this general patient service unit, located on the south side of Lakeside Hospital, has been made possible by the mild winter weather and changes in construction plans, allowing work in every area of the building to progress simultaneously.

The five-floor Bishop Building will contain more than 190,000 square feet and will house such major departments as Surgery, Radiology, Dietary, Accounting and Medical Records. When completed, the building will tie in with Lakeside Hospital on three sides and will join with the planned Rainbow Babies and Childrens Hospital, the future George M. Humphrey Ambulatory Care Center and the pro-

posed addition to the Institute of Pathology. It will be joined by tunnel with all units of the Medical Center.

Several areas of the Bishop Building will be ready for occupancy during 1965. This summer the main basement corridor to Babies and Childrens Hospital and MacDonald House will be completed. The x-ray therapy unit, located in the basement, has a tentative fall occupancy date and the adjacent diagnostic x-ray unit is scheduled for partial occupancy in late fall, with full operation planned for the spring of 1966.

### COMING MEETINGS

#### Ohio State Medical Association:

1966 Annual Meeting, Cleveland, Week of May 22.

1967 Annual Meeting, Columbus, Week of May 14.

1968 Annual Meeting, Cincinnati, Week of May 12.

#### American Medical Association:

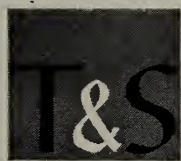
1965 Annual Convention, New York City, June 20 - 24.

1965 Clinical Convention, Philadelphia, Nov. 28-Dec. 1.

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# Ohio Academy of General Practice . . .

## Fifteenth Annual Scientific Assembly Scheduled In Toledo for Three-Day Session, August 17-19

**A**LL physicians, including residents and interns, have been issued a special invitation to attend the 15th Annual Scientific Assembly of the Ohio Academy of General Practice, to be held at the Commodore Perry Hotel, in Toledo, Tuesday, August 17 to Thursday, August 19.

Breakfast and luncheon sessions will be limited in attendance and arrangements to attend these programs should be made in advance with Robert Wilson, Executive Secretary, OAGP, 4075 N. High Street, Columbus, Ohio 43214.

The program has been announced as follows:

### Tuesday Afternoon, August 17

(Registration opens at Noon)

**Complete Neurological Examination** — Dr. Robert C. Atkinson, Columbus.

**Office Ophthalmology the Family Doctor Should Practice** — Dr. Malcolm A. McCannel, Minneapolis, Minnesota.

**Gout** — Dr. Richard T. Smith, Philadelphia, Pa.

**The Family Doctor and the Computer** — Otto H. Schmitt, Ph. D., Minneapolis, Minn.

### Wednesday Morning, August 18

**Breakfast Session 1: Medical Care for Adolescents** — Dr. Thomas E. Cone, Boston.

**Breakfast Session 2: Accentuating the Positive in Rheumatology** — Dr. Smith.

**Breakfast Session 3: Bifocals, Bruises and Bugs**, Dr. Malcolm A. McCannel.

**D & C Fumbles** — Dr. Buford Word, Birmingham, Alabama.

**Functional Uterine Bleeding** — Dr. Robert B. Greenblatt, Augusta, Ga.

**Shocking News About Shock** — Dr. Philip Thorek, Chicago.

**Hiatus Hernia** — Dr. W. Arnold McAlpine, Toledo.

### Noon Luncheon Sessions

**Luncheon Session 1: The Acute Abdomen** — Dr. Thorek.

**Luncheon Session 2: Trauma** — Dr. John A. Siegling, Charleston, S. C.

**Luncheon Session 3: The Tall Girl Syndrome** — Dr. Robert B. Greenblatt.

**Luncheon Session 4: Diagnosis and Treatment**

**of Thrombophlebitis and Its Complications** — Dr. Victor G. deWolfe, Cleveland.

**Luncheon Session 5: Cancer of the Stomach** — Dr. Gordon McNeer, New York City.

### Wednesday Afternoon

**New Drugs of Past Two Years** — Arthur Tye, Ph. D., Columbus.

**The Diagnosis and Management of Malignant Melanoma** — Dr. McNeer.

**Pitfalls of Fracture Care** — Dr. Siegling.

**Arterial Embolism: Diagnosis and Treatment** — Dr. DeWolfe.

### Wednesday Evening

**Emotional Problems of the Adolescent** — Dr. Beverly T. Mead, Omaha, Nebraska.

### Thursday Morning, August 19

**Adolescent Medicine** — Dr. Cone.

**Newer Concepts in the Management of Obesity** — Theodore G. Duncan, Philadelphia.

**Recent Advances and Changes in Treatment of Diabetes** — Dr. Leo P. Krall, Boston.

**Nutrition in Teenagers** — Dr. Willard A. Krehl, Iowa City.

**Anxiety and Depression** — Dr. Mead.

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### Copies of Joint Statement on TB Control Are Available

Officials of the Ohio Tuberculosis and Health Association have requested *The Journal* to call attention of its readers to the following information:

In the March, 1956 issue of *The American Review of Respiratory Diseases* and in the March issue of *Diseases of the Chest*, there appears a joint statement of the Therapy Committees of the American Thoracic Society and the American College of Chest Physicians. The statement deals with the report of the Surgeon General's Task Force on Tuberculosis Control and points up the important contribution that practicing physicians have to make in implementing the Task Force Recommendations.

Copies of the statement may be obtained from the Ohio Tuberculosis & Health Association, Mr. John A. Louis, Executive Director, 1575 Neil Avenue, Columbus, Ohio 43201.



# to assure pain relief in relaxant therapy

In painful skeletal muscle spasm, relief of pain does not always follow relaxant therapy, as in the presence of—

**Provocative pain**, when muscle spasm is triggered by some underlying musculo-skeletal defect.

**Residual pain**, when relaxation of severe spasticity leaves a degree of myalgia that continues to cause discomfort.

**Severe pain**, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

**Emotionally aggravated pain**, when anxiety or agitation creates tensions that undermine the efficacy of relaxant medication.

For decisive relief—lest persistent pain overshadow the benefits of relaxant therapy—many physicians prescribe ROBAXISAL or ROBAXISAL-PH.

## Synergistic double action

In ROBAXISAL the potent action of the well-recognized skeletal muscle relaxant Robaxin (methocarbamol)<sup>1,2,3,4,5,6,8</sup> is accompanied by the time-tested analgesia of aspirin. This “rational therapeutic combination”<sup>7</sup> proves especially effective, since clinical studies have attested that the concurrent ingestion of methocarbamol and aspirin produces higher salicylate levels than equivalent doses of aspirin alone<sup>7</sup>...with “gratifying relief” of pain as well as spasm.<sup>7</sup>

**INDICATIONS:** Strains and sprains, painful disorders of the back, “whiplash” injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

**CONTRAINDICATIONS:** Hypersensitivity to any one of the components.

**SIDE EFFECTS:** Lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with unusual sensitivity to drugs, but usually disappear on reduction of dosage.

## Supplementary sedation

In ROBAXISAL-PH, the relaxant Robaxin is combined with the analgesic-sedative ingredients of the popular Phenaphen formula, for use when emotional tensions aggravate the spasm-pain syndrome. Anxiety is eased by the phenobarbital component, which also enhances analgesic effects; and any tendency to gastric upset is minimized by hyoscyamine in the formulation.

**References:** 1. Carpenter, E. B., South. M.J. 51:627, 1958. 2. Crookshank, J. W.: J. Louisiana State Med. Soc. 114:272, 1962. 3. Feinberg, I., et al.: Am. J. Orthoped. 4:280, 1962. 4. Fitzgerald, W. J.: Miss. Valley M.J. 82:146, 1960. 5. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 6. Meyers, G. B., and Urbach, J. R.: Penna. M.J. 64:876, 1961. 7. Truitt, E. B., Jr., Morgan, A. M., and Nachman, H. M.: South. M.J. 54:318, 1961. 8. Weiss, M., and Weiss, S.: J. Am. Osteopath. Assn. 62:142, 1962.

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Each pink-and-white laminated Tablet contains:  
Robaxin® (methocarbamol, Robins) ..... 400 mg.  
U. S. Pat. No. 2770649  
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Robaxin® (methocarbamol, Robins) ..... 400 mg.    Hyoscyamine sulfate ..... 0.016 mg.  
Phenacetin (1½ gr.) ..... 97 mg.    Phenobarbital (¼ gr.) ..... 8.1 mg.  
Aspirin (1¼ gr.) ..... 81 mg.    (Warning: May be habit forming.)

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## Disaster Medical Care Conference To Be Held October 30-31

The 16th National Conference on Disaster Medical Care will be held at The Drake in Chicago, October 30-31, it was announced by Albert H. Schwichtenberg, M.D., chairman of the American Medical Association's Council on National Security.

Four symposiums—Care of the Traumatized Patient, Disaster Communications, Disaster Planning in Industry, Disaster Medical Resources—will be held during the two-day period to develop the conference theme of unified health resources planning for disaster.

"The Red Cross in Disaster" will be the subject of a Saturday luncheon address by Robert F. Shea, Washington, D.C., vice president, American National Red Cross. James Z. Appel, M.D., Lancaster, Pa., AMA president will address the conference Sunday morning.

Three representatives of the federal government will conclude Saturday's discussions with a presentation of the role of "Federal Agencies in Disaster."

A Special Disaster Tornado Report will be presented during a Sunday morning breakfast session. A second highlight of Sunday morning's session will be three separate workshops specifically designed for

the physician, allied health worker, and community leaders.

Following a presentation of the New York method of planning for disaster, William T. Ramage, Jr., M.D., Louisville, Ky., program chairman, will deliver the conference summary.

For additional information write: Council on National Security, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

## Catalog Lists Films on Health Topics for Lay Viewing

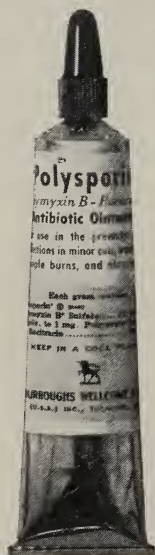
A new catalog containing descriptions of 184 motion pictures suitable for lay viewing and pertaining to the health field has been issued by the Pharmaceutical Manufacturers Association.

The films are available on a free loan basis to both lay and professional groups.

All of the films were produced by prescription drug firms, but do not promote products. All are 16mm sound. Running times range from 10 to 60 minutes.

Copies of the catalog are available upon written request to the Director of Public Information, Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N. W., Washington, D. C. 20005.

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## Grants from Heart Association Go To Several Ohioans

Five fellowship awards and nine grants-in-aid for heart research in Columbus, Cincinnati, and Cleveland are being supported by the American Heart Association for July 1, 1965 - June 30, 1966.

The announcement was made by Dr. John A. Rogers, Youngstown, president of the Ohio State Heart Association.

The Ohio awards are among 297 made by the national association in 36 states and Canada, totaling nearly \$4 million.

In addition, \$6 million will be spent by heart chapters throughout the country for local projects in the year ahead, bringing the heart research total to \$10 million. This sum represents the largest single non-governmental source of cardiovascular research support in the world.

The five Ohio fellowship recipients announced are among 95 in the country to receive individual support as Established Investigators — scientists of proven ability who are supported for five-year periods.

They are: Dr. Nathan Paul, Cincinnati, May Institute for Medical Research; Dr. Virginia H. Donaldson, Cleveland, St. Vincent Charity Hospital; Dr. Philip W. Hall, III, Cleveland Metropolitan Hospital; and Dr. Gerald P. Brierley and Dr. Heinz P. Pieper, Columbus, Ohio State University College of Medicine.

Grants-in-aid will support studies by the following: Dr. Gunter Grupp, University of Cincinnati College of Medicine, \$9,295, regulation of blood flow through the kidney; Dr. Nathan Paul, May Institute for Medical Research, Cincinnati, \$7,040, transplantation of the kidney; Dr. John W. Corcoran, Western Reserve University School of Medicine, Cleveland, \$7,150, a study of antibiotic compounds affecting the heart.

Also, Dr. Bernard B. Landau, Western Reserve University, \$8,305, how sugar is metabolized in fatty tissue; Dr. Virginia H. Donaldson, St. Vincent Charity Hospital, Cleveland, \$5,445, clot-dissolving mechanisms in the blood; Dr. Philip W. Hall, III, Cleveland Metropolitan General Hospital, \$5,830, relationship of blood protein chemicals to minerals.

Also, Dr. Salvatore Sancetta, Cleveland Metropolitan General Hospital, \$8,635, effects of body chemicals in the blood stream; Dr. Heinz P. Pieper, Ohio State University College of Medicine, \$9,990, pressure flow in the coronary system; and Dr. Arnold M. Weissler, Ohio State University College of Medicine, \$13,255, study of digitalis.

A program to create a collection of original oil paintings of the medical colleges of America has been launched by E. R. Squibb & Sons, pharmaceutical manufacturers. The first painting recently was presented to The Jefferson Medical College of Philadelphia.

## Hygroton®

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**Indications:** Many types of edema involving retention of salt and water.

**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.

**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

**Average Dosage:** One tablet (100 mg.) daily with breakfast.

**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.

For full details, see the complete prescribing information.

\*Dorhout Mees, E.J., and Geyskes, G.G.: Acta med. scandinav. 175:703, 1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.



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Hygroton, brand of chlorthalidone, gets rid of edema efficiently. Your edematous patients will generally need far fewer tablets than with most diuretics. And they'll generally save more on prescription costs. One tablet a day is a popular dosage. So is one tablet every other day. You may even find half a tablet three times a week does the job. No other diuretic works as long. And none has as much natriuretic activity per tablet.\* For good riddance of edema with the least number of tablets, prescribe Hygroton, brand of chlorthalidone.

**Hygroton**<sup>®</sup> brand of  
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## Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

\* \* \*

There are certain drugs which are very hazardous to the fetus. There are others which, experiments indicate, may be dangerous. Then there are those drugs which are circumstantially suspected of being hazardous. This leaves few drugs available for use. Medication cannot stop altogether while physicians wait for the future to provide the answers. As current guide lines, when the parturient needs treatment, drugs must be judged not on the impossible basis of absolute safety, but on a basis of no known added risk. With such a standard, the physician can continue to prescribe for his patients. — Editorial in *Massachusetts Physician*, 23:7, (Mar.) 1965.

\* \* \*

It is all very well for the profession and the public to be alert and alarmed at drug reactions, and to do everything in their power to keep these at a minimum. Nevertheless, to me . . . the pendulum has swung much too far in the other direction, to the extent that many individual members of the public,

to my personal knowledge, are more concerned about nonexistent reactions than they are with the evident benefit they have obtained from the drug they are taking. — Irwin C. Winter, Ph. D., M. D., in *Journal of New Drugs*, 4:6 (Nov.-Dec.) 1964.

\* \* \*

Almost 600 new basic chemical and biological drugs were developed in the last 30 years. In spite of plant expansion, labor costs and research expenses, pharmaceutical prices have gone down 13.8 per cent since 1949 compared to a rise of 26.7 per cent in the Wholesale Price Index of the Bureau of Labor Statistics. Being acutely aware of the attacks on the American pharmaceutical industry by our national government and its committees, it is interesting to note that if all drug advertising were eliminated, it would amount to a saving of some 5 cents on a dollar for a prescription item. This is one of the major things the Kefauver committee was trying to do. How the medical profession would be affected by such a restriction is hard to envisage and what it would do to the drug industry might well be catastrophic unless, of course, the doctors were required to prescribe only from a government formulary as was tried by the government of Australia in 1949. — W. Albert Brewer, M. D., in *Arizona Medicine*, 22:2, (Feb.) 1965.

### Changed Your Address? If So, Send the New One to Us Promptly

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## **“All Registered Nurses are Alike”**

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



## Today's Health Guide Available In Book Form from AMA

The American Medical Association has announced publication of *Today's Health Guide*, the AMA's new manual of health information and guidance for the American family.

The 640-page book, in two colors throughout, includes 90 chapters, each dealing with an important aspect of health in the family. It is illustrated by hundreds of easy-to-understand drawings, including "trans-vision," or full color "see through" drawings, of the organs and systems of the human body.

The manual is an inclusive compendium of information about health which will be most helpful to the family in making the best and most economical use of the sources of health information, preventive medical services, treatment of illness and adequate meeting of emergencies.

*Today's Health Guide* is a non-profit public service enterprise of the American Medical Association. It is available by mail order from the AMA at 535 N. Dearborn St., Chicago, for \$4.95. Check or money order should accompany each order.

Dr. Gordon Savage discussed "Tuberculosis and Its Research," before the Greene County branch of the Forty-and-Eight, veterans organization.

## New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during May. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

<b>Cuyahoga</b>	<b>Logan</b>
David P. Agle, Cleveland	Josip Terebuh, Bellefontaine
Francis E. Cuppage, Cleveland	
<b>Erie</b>	<b>Lucas</b>
Dean J. Reichenbach, Sandusky	Marilyn Hart, Toledo
<b>Franklin</b>	<b>Marion</b>
David R. Rudy, Columbus	Jerome A. Wensinger, Marion
Juan F. Sotos, Columbus	
<b>Hamilton</b>	<b>Medina</b>
Richard C. Fleming, Cincinnati	Benedict B. Lenhart, Lodi
Franz L. Geeraerts, Cincinnati	
John A. Huesing, Cincinnati	<b>Montgomery</b>
Yasuo Sasaki, Cincinnati	Richard C. Miller, II, Dayton
Helen McGregor Smith, Cincinnati	Miguel G. Nieto, Dayton
	<b>Richland</b>
	Fernando Mata, Mansfield

"Heart Disease" was the subject discussed when the Huron Road Hospital of East Cleveland held its 11th annual Spring Seminar, presented jointly by the hospital and the Cleveland Chapter of the American Academy of General Practice.

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

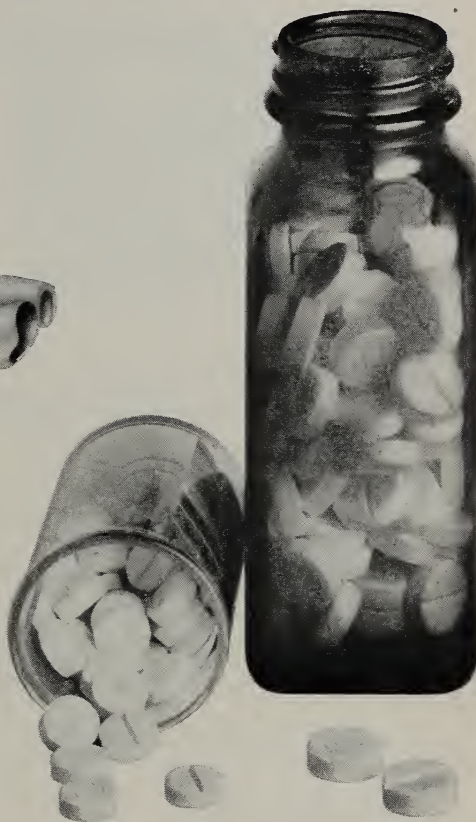
Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
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# Health Officers of Cincinnati, Ohio And the Problems of Their Day

KENNETH I. E. MACLEOD, M. D., M. P. H.\*

## PART II

*(Continued from June Issue)*

THE health officer's concern with housing conditions is noteworthy. The city's early concern with poverty is also noteworthy as we read an early mayor's comments. In his annual message for 1864, the honorable L. A. Harris wrote:

... I may, in this connection, say a few words, suggested by a topic too often intimately connected with the subject of crime—I mean that of poverty . . . Those applying for aid at the Mayor's office are mostly of that class to whom the ordinary and public avenues of relief are closed . . .

### First Housing Survey in U. S. A.

As a result of the Board of Health's concern with inadequate housing and cellar dwelling, it authorized and carried out the first Housing Survey attempted anywhere in the United States.

In his annual report for 1868, Dr. Clendenin made the following observation:

... There are 1,410 tenement houses in this city, each containing over six or more families to a house . . . A very considerable proportion of these tenement houses have only one stairway or means of entrance and exit; the number of stories varies from two to six, so that in the case of fire it would be almost impossible for many of the inmates to escape alive . . .

Dr. Clendenin's expenditures that year amounted to \$21,500. Out of this came payments to the district physicians for serving 4,431 patients—a total of home and office visits of 20,874.

Dr. Clendenin continued as health officer to the city until 1873. As one reads his annual reports one gets the impression of a well educated physician imbued with a great humanitarian spirit, whose endeavors on behalf of the poor are supported most wholeheartedly by the Board of Health, and presumably also by City Council.

### Dr. J. J. Quinn: 1873-1876

Dr. J. J. Quinn, as successor to Dr. Clendenin, found as one of his first tasks the need to control an epidemic of cholera. He wrote in his report for 1874,

This dread visitor, however, did not make its appearance unheralded. The earliest efforts of the Health Officer, were

given to placing the city in the best possible sanitary condition . . . Circulars were distributed by the Board of Health . . . warning the citizens of the impending danger. It is a fact worthy of record, that, from the time the sanitary organization was completed . . . the disease was speedily confined within safe limits . . .

Dr. Quinn appended a complete report of the actual cases of cholera, the statistics and epidemiology of the outbreak in 1873.

In this same report, the health officer deplored "the frightful rate of mortality among children from year to year 'due to swill milk.' There can be no doubt that milk from swill cattle is more poisonous to infants than is alcohol to adults . . ."

He also drew attention to the sanitation problems in the city and the need for proper sewerage, the importance of which "cannot be overestimated." Perhaps some of those of us living today in Hamilton County might wish we had paid more serious attention to his advice, because prevention was always better and less expensive than cure.

The leading causes of death during this mid-century period make grim reading—consumption, infantile convulsions, various lung infections, typhoid fever, cholera, brain congestion (probably encephalitis), meningitis, croup (probably included diphtheria), and heart disease. It is notable that one third of the babies born in Cincinnati during these years died before attaining their first birthday. (Today the infantile mortality rate runs about 28 to 29 per 1,000 live births.)

During this period (1867) a permit system on milk shippers into the city was established. In 1874, the State legislature enacted a law requiring the reporting of births and marriages as well as deaths. The Board of Health was also empowered to hire milk and meat inspectors.

### Dr. Thomas H. Kearney: 1876-1878

In 1876 the Board of Health was abolished by act of City Council, and the Health Officer, Dr. Kearney, was ordered to report to the Board of Police Commissioners.

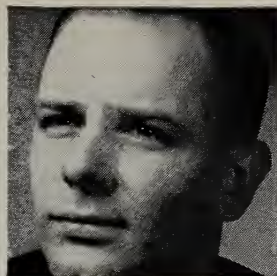
The Health Department had a staff consisting of the health officer, a secretary, a milk inspector, a

\*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.  
Submitted October 4, 1964.

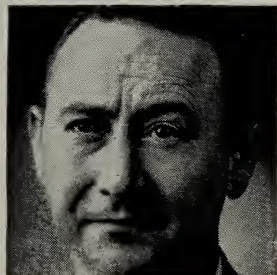




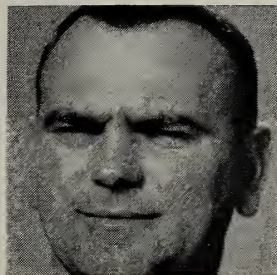
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sanitary superintendent, a superintendent of markets, and several meat inspectors. There were also some 25 district physicians.

In his transmittal letter to the City Council, the President of the Board of Police Commissioners, S. F. Covington, wrote: "It was deemed expeditious to appoint one District Physician for each Ward, without, however, increasing the aggregate amount of the expense on this account . . ."

And shades of the "chisellers" afflicting the back of Welfare today, as complained of in Newburgh, New York, and elsewhere, Dr. Kearney stated: ". . . It is highly probable that many of those on the lists of the 'indigent sick' are taking more or less medicine from whim, or for no better reason than because they get it for nothing . . ." Nevertheless, Dr. Kearney, "the very able Health Officer," as his President called him, added: ". . . The District Physicians have been particularly instructed to use care and judgement in ordering medicine, and not to prescribe it merely to gratify the wishes of individuals . . ."

#### Dr. Thomas C. Minor: 1878-1879

Dr. Thomas C. Minor, who succeeded Dr. Kearney in rapid enough succession, hinting pointedly at the precariousness of tenure in the position, in his annual report for 1878 was obviously relieved at the re-creation of the Board of Health when he wrote: "Gentlemen — In compliance with the law creating the Board of Health, I have the honor to submit . . ."

One of Dr. Minor's first acts was to reorganize the department into four bureaus — the Bureau of Vital Statistics, the Bureau of Medical Relief, the Bureau of Sanitary Inspection, and the Bureau of Markets.

#### The Bureau of Medical Relief

This important Bureau had its origins long before even in the earliest days of the century — probably as early as 1826 with the appointment of "an examining physician." But even before this, the City Council permitted physicians to be paid their expenses for attendance upon patients with smallpox. In 1845, under an ordinance enacted that year, the Council was authorized "to provide medicine and care for the sick poor of the city." A hospital for the care of infectious, contagious, and malignant diseases was established in 1851, and frequent references are made in the city documents to "care for the out-door poor."

But it is not until 1867 we find the district physicians mentioned as such in the records of the Health Department. Under a reorganization of the Board of Health in 1868, the powers of providing medical relief to the poor was transferred from the Infirmary Board to the Board of Health. The annual report for that year indicates that there were 13 "ward" physicians. But in the following two years their number was increased to 26. In 1870 the total salaries for these physicians amounted to \$7,005.

The average cost of medical attendance and medi-

cine to the sick poor averaged \$2.07 — a sizeable sum for those days. But Dr. Minor had the following comments to make on those costs: ". . . As all these patients were entitled to enter the City Hospital for treatment, where the average expense would have been at least 70 cents per diem, the large pecuniary saving to the city is at once noticeable . . ."

It is curious that this early example of a salaried governmental health services is still with us, although the author is anxious to note its demise in the very near future, and the system replaced by some type of arrangement as exists in Baltimore, Maryland, where the indigent may obtain home and office attendance at a fee for service payable by the Health Department by "physicians of their choice" among those willing to render such service.

#### Yellow Fever in Ohio

Dr. Minor closed his report for 1878 with a quite remarkable, 130-page account of the occurrence of yellow fever in Ohio. In his introduction he quotes from Dr. Drake, disagreeing with the latter's general thesis that

Yellow fever has never appeared in this State in an epidemic form . . . (contrariwise) The epidemic outbreak at Gallipolis, during September of the present year, is most favorable proof positive that the disease, under certain favorable conditions may become epidemic in this State . . .

Dr. Minor indicates in this able report much insight into the nature and origins of this deadly disease. All he seems to be missing is the vector. "The fact that parties developing the disease at Cincinnati failed to give the disease to either physicians or nurses is no argument the disease is not contagious," he contended with considerable emphasis.

#### A Sanitary Survey of Cincinnati

Dr. Thomas Minor was clearly a most lively and observant health officer. As part of his responsibility during 1879, he completed a survey of the sanitary status of Cincinnati, at the request of the National Health authorities in Washington, D. C.<sup>†</sup> This consisted of a printed list of questions covering such topics as location, climate, topography, water supply, drainage, and sewerage, streets and public grounds, habitations, gas and lighting, garbage and excreta, markets, slaughterhouses and abattoirs, manufactories and trades, public schools and buildings, hospital and public charities, police and prisons, fire establishments and burials, public health laws and sanitary regulations, registration and statistics of deaths and diseases, quarantine, harbors and docks, and finally, municipal expenditures on public health and sanitation.

*(To Be Continued in August Issue)*

\*This is still one of the problems, the proper dividing of the load between Cincinnati General Hospital and the Health Department in providing health care to the indigent, and is most worthy of solution.

†The National Health Department lasted only five years.





# Scientific Section

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No. 7

## Infectious Hepatitis

### Report of an Outbreak Apparently Halted by Injections Of Gamma Globulin

T. AIDAN COCKBURN, M.D., BARBARA L. RICHARDS, R.N., CATHERINE E. LUDLOW, R.N.,  
and KENNETH I. E. MACLEOD, M.D.

AN OUTBREAK of infectious hepatitis occurred in a new federal housing project in Cincinnati in the latter half of 1963. Epidemiological data would suggest that the outbreak was water-borne, although no definite proof of this was forthcoming. Protection with gamma globulin in the dosage of 0.01 ml. per pound of body weight was administered to approximately 450 of the 530 persons at risk. This procedure together with abatement of sanitary defects apparently stopped the outbreak immediately.

#### Description of the Area

The housing project within the city limits of Cincinnati consists of one section built 20 years ago and housing about 2700 people, and a smaller section built two years ago accommodating about 530. The older housing estate (Section A) is on the top of a hill, with the newer one (Section B) being some 50 feet lower, on the top of a spur of land jutting into a valley. The sides of the spur slope sharply to the floor of the valley (Charts 1 and 2).

Subsequent investigation showed that land slides had occurred in the sides of the spur of land on which the smaller newer estate had been built. One

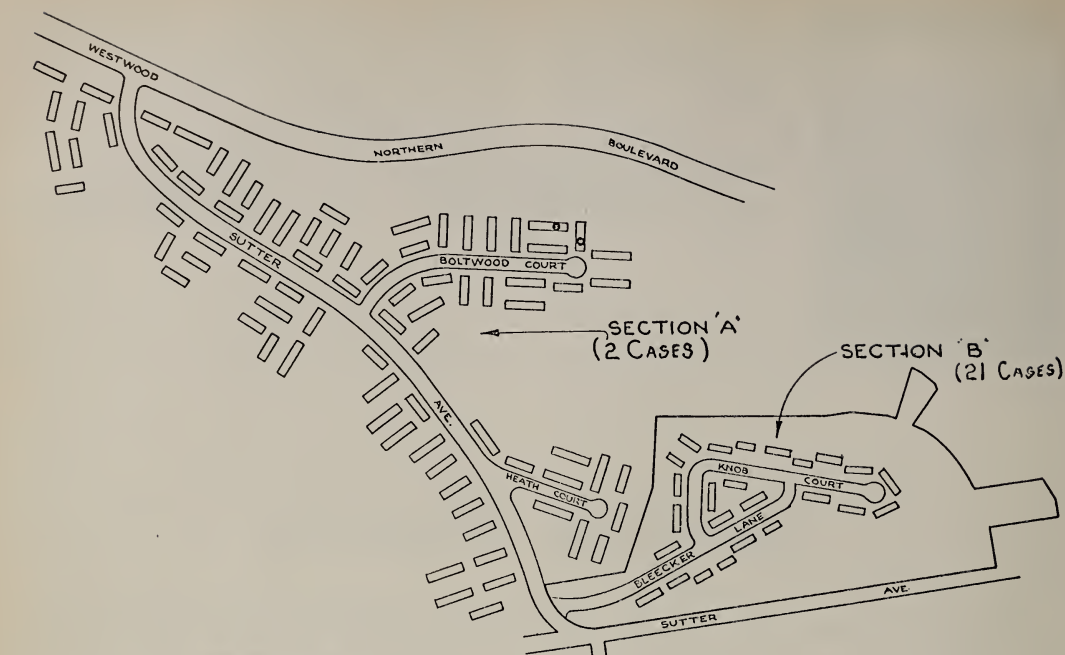
#### The Authors

- Dr. Cockburn, Cincinnati, is Assistant Commissioner of Health, and Director, Division of Research, Cincinnati Health Department.
- Miss Richards, Cincinnati, is District Supervisor, Public Health Nursing, Cincinnati Department of Health.
- Miss Ludlow, Cincinnati, fellow, American Public Health Association, is Superintendent, Bureau of Public Health Nursing, Cincinnati Health Department.
- Dr. Macleod, Cincinnati, is Commissioner of Health for the City of Cincinnati.

building of six apartments had had to be abandoned for some six months because the land on which it was situated had slid a little down the hillside.

The housing estate was one constructed with federal assistance. Many of the people living in it were on welfare relief and all belonged to the lower income wage brackets.

In November 1963, public health nurses made a house-to-house survey of Section B. They counted 130 families and were able to interview 110 of these. The remaining 20 families consisted largely of one



# HOUSING ESTATE CINCINNATI, OHIO SECTIONS A & B

• INFECTIOUS HEPATITIS CASE  
(SECTION A ONLY)

Chart 1

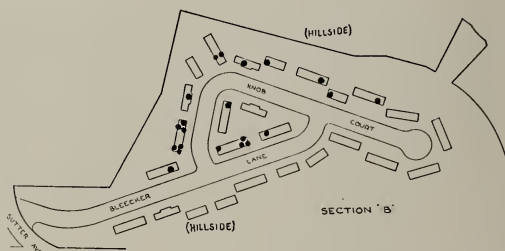
or two persons per family, who were away at work during the interviewing hours. The age distribution of the 514 persons in the 110 families is given in Table 1. The total population would be about 550 persons.

## History of the Outbreak

Every case of infectious hepatitis in Cincinnati is investigated by the Health Department, including a home visit by a public health nurse. In 1962-63, it became apparent that some of the cases reported were concentrated in one very small area (Charts 1 and 2). The chronology of the outbreak is given in Chart 3. By November 1963, enough cases had occurred within a very small radius as to cause alarm. The results of the inquiries and epidemiologic studies made failed to incriminate any transmission by blood transfusion, injection, or food. A study of the social habits of the families concerned, indicated that transmission by personal contact was unlikely to account for the outbreak. On the other hand, the groupings of the cases, as indicated in Chart 2, indicated the strong possibility that the infection may have been spread by water.

The housing authorities and the water department

were alerted to the fact that the epidemic existed and the possibility that it might be due to contamination of the water supply. A thorough check was made of all mains, connecting pipes, and sanitary conveniences, and a number of defects were discovered, but no one factor could be found to account for the outbreak. There were a number of minor defects such as temporarily blocked pipes, so that, for instance, the flushing of a toilet in one second floor



# HOUSING ESTATE CINCINNATI, OHIO SECTION B

• INFECTIOUS HEPATITIS CASE

Chart 2



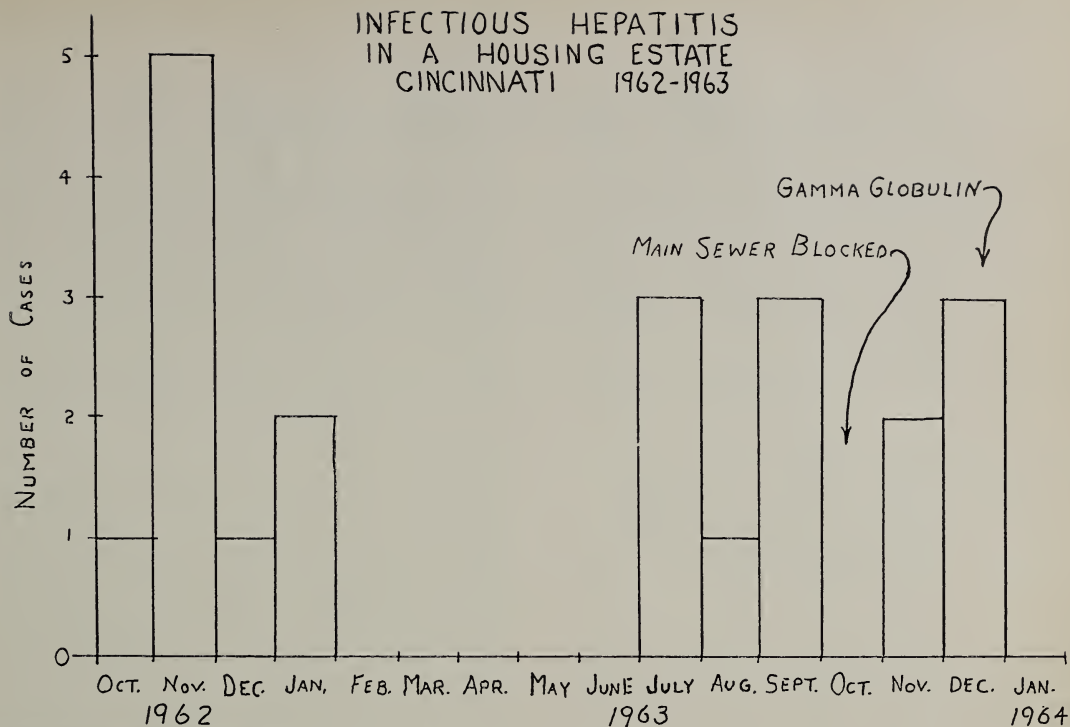


Chart 3

apartment led to the rise of water in the bath in the apartment below. Much more serious was a temporary blockage of the main sewage pipe leading from the housing estate. In October, 1963, vandals had lifted up the cover of an inspection chamber and filled the chamber with rocks, thereby blocking the sewer. This led to the seepage of sewage higher up the hillside so that it ran down the street of Section B. A pond formed, and children sailed their boats on this pond; it was three or four days before it was realized that the water was in fact sewage.

Even more serious was the information that land slides were occurring on the sides of the spur of the hill on which the newer housing estate was placed. The possibility of contaminated water resulting from broken water and sewage pipes had to be considered. One block of six apartments was affected by a landslide and had been evacuated. Two of the people from this apartment block subsequently developed infectious hepatitis. At least two other water pipe breaks were known to have occurred in 1963, and there may have been others that were repaired but

TABLE 1. *Infectious Hepatitis in the Affected Area, Cincinnati, Ohio  
November 1962 - December 1963*

Total Number of Families — 130			Families Interviewed — 110			Persons Interviewed — 514		
AGE GROUPS	MALES		FEMALES		TOTALS			
	Total Popu- lation	Patients With Jaundice	Total Popu- lation	Patients With Jaundice	Total Popu- lation	Patients With Jaundice		
0 — 4	48	0	47	1	95	1		
5 — 9	52	1	63	6	115	7		
10 — 19	56	7	62	3	118	10		
20 — 29	13	0	31	1	44	1		
30 — 39	25	1	30	1	55	2		
40 — 49	17	0	16	0	33	0		
50 — 59	6	0	3	0	9	0		
60 +	12	0	33	0	45	0		
TOTALS	229	9	285	12	514	21		

not reported to the Health Department. By December, all water and sanitary defects were corrected.

In November 1963, public health nurses made door-to-door visits in Section B looking for cases of infectious hepatitis, jaundice, or illnesses without jaundice otherwise resembling infectious hepatitis that had occurred in the previous three months. Inquiries were made about every person with regard to the following: jaundice, vomiting, diarrhea, nausea, fever, malaise, anorexia, abdominal discomfort, light stools, and dark urine. No new cases of jaundice were discovered, but a surprisingly large number of the people reported illnesses in the previous three months with symptoms listed on the questionnaire. The data for both infectious hepatitis and these other, undiagnosed illnesses are given in Tables 1 and 2.

TABLE 2. *Intestinal Illness Without Jaundice in Affected Area, Cincinnati, Ohio, September - November 1963*

Total No. of Families—130; Families Interviewed—110 Persons Interviewed—514			
Age Groups	Males	Females	Totals
0 — 4	5	4	9
5 — 9	4	6	10
10 — 19	5	7	12
20 — 29	3	1	4
30 — 39	0	1	1
40 — 49	2	3	5
50 — 59	0	0	0
60 +	1	1	2
Totals	20	23	43

Only two cases of infectious hepatitis occurred in Section A with its population of 2700 in the 13 months of November 1962 to December 1963. There were 23 cases in the 550 persons in the new estate in that same period. For comparison, there are about 200 cases per year reported for the city as a whole, with its half million population, an annual attack rate of about 0.4 per thousand.

On December 10th, about 80 per cent of the population of Section B was injected with gamma globulin. The last two cases occurred two days after the injections of gamma globulin. There have been no new cases in the 12 months following these injections.

### Protection with Gamma Globulin

There is no general agreement as to dosage of gamma globulin required to give protection against infectious hepatitis. The original observations on the efficacy of gamma globulin indicated that 0.01 ml. per pound of body weight was sufficient to give at least 90 per cent protection, but a minimal dosage of 0.02 ml. per pound has become more customary in recent years. The manufacturers recommend dosages ranging from 0.02 to 0.10 ml. per pound of body weight. In practice in Cincinnati, the majority of practitioners seem to be giving the maximum dosage recommended. Gamma globulin is expensive, so that protection given to a family consisting of

father, mother, and two children would cost about \$60 for the gamma globulin alone, when maximum dosages are employed.

In Ohio, the state health department supplies gamma globulin through local authorities to family contacts of cases of infectious hepatitis. For the past three years, this has been issued by the Cincinnati Health Department to contacts within the city limits in the dosage of 0.01 cc. per pound of body weight. Follow-up of the contacts has failed to discover any cases among the persons protected in this fashion. This was the procedure followed both in Sections A and B during the year of 1963 up to December 10th. By December 10, 1963, approximately 50 persons in Section B had received protection in the previous three months, while 21 had had the disease since November 1962.

Mass protection was offered to the population in the new housing project and gamma globulin administered on December 10, 1963. The operation was carried out with the assistance of the Cincinnati Health Department Volunteers. All receiving protection were weighed before injection and received 0.01 ml. per pound of weight. Those attending numbered 391, as listed in Table 3. Out of a total of about

TABLE 3. *Persons Protected with Gamma Globulin December 10, 1963*

Age	Males	Females	Totals
3 Mos. — 4 Yrs.	32	30	62
5 — 9	43	55	98
10 — 19	46	61	107
20 — 29	10	20	30
30 — 39	8	31	39
40 — 49	11	15	26
50 — 59	4	5	9
60 +	3	17	20
Totals	157	234	391

550 residents, 464 had either been injected with gamma globulin within three months or had had the disease.

One person developed infectious hepatitis on the day of injection and two others on December 12th. Since that date to the present (December 31, 1964), there have been no further cases in Section B.

### Summary

1. An outbreak of infectious hepatitis occurred in the new housing estate. Twenty-one cases in a population of 530 were reported over a period of 13 months.
2. The most likely cause of the outbreak was contaminated water supply, but this could not be proven.
3. Mass protection to the population was given using gamma globulin in the dosage of one ml. per 100 pounds of body weight. There have been no further cases for a period of 10 months, apart from those appearing within three days of the injections.



# Head and Neck Surgery

## Part I. The Management of Cancer of the Tongue

ARTHUR G. JAMES, M.D., and JOSEPH A. BONTA, M.D.

NOT ONLY is cancer of the tongue the most common malignant tumor in the oral cavity, but it causes more deaths each year than any other head and neck cancer. It has been estimated that this lesion accounts for 2 to 3 per cent of all human cancers.<sup>1</sup> This disease occurs in both sexes, more often in the male and most often in the fifth to seventh decades, but it has been noted in the teens. It may occur in any part of the tongue but is most frequently found on the lateral aspects and especially in the middle third. The second most common primary site is the base. This disease tends to be almost symptomless in its early stages. The patient usually discovers the lesion himself, either the primary lesion or the metastatic deposit in the neck. If the lesion occurs in the base of the tongue, hoarseness or dysphagia may occur.

### Material

One hundred and sixty-two (162) patients with cancer of the tongue were treated personally by the authors during a thirteen year period. Eighty-nine (89) of these qualified for five year end results studies. Fifty-seven (57) of these cases were males; thirty-two (32) were females. Fifty-two (52) of the lesions occurred in the anterior two thirds of the tongue and thirty-seven (37) of them occurred in the base.

### Diagnosis

Any abnormal lesion of the tongue should be suspected of malignancy. Several diseases have to be considered in the differential diagnosis. Other clinical factors to be considered are age, sex and the general appearance of the lesion. The final diagnosis, however, is always made by a biopsy.

### Differential Diagnosis:

(1) Herpes — This usually is a very tender lesion and has a duration of only 10 to 14 days.

(2) Vitamin deficiency — There is usually a history of nutritional lack. This lesion tends to be more generalized, diffuse and superficial (Figure 1).

(3) Leukoplakia — This may cover any part or all of the tongue. It may be very superficial or it may become thickened. Its etiology is unknown but it is

### The Authors

● Dr. James, Columbus, is Director, Columbus Cancer Clinic; Associate Professor, Department of Surgery, The Ohio State University College of Medicine.

● Dr. Bonta, Columbus, is Senior Attending Surgeon, Riverside Methodist Hospital.

also associated with smoking and dental caries. Figure 2 represents an example of a simple leukoplakia.

(4) Tuberculosis — This is a non-neoplastic lesion that must occasionally be differentiated from carcinoma.

(5) Chronic inflammation due to trauma. This is usually due to dental caries.

### Clinical Factors:

(1) Age — One cannot exclude the possibility of cancer on the basis of age alone. It is indicated above that this occurs most commonly in the elderly. Figure 3 is an example of a carcinoma of the lateral aspect of the tongue in a 17 year old girl.

(2) Sex — Cancer of the tongue has been reported by many to occur more frequently in the male than in the female. It has been stated that this occurs four to five times as commonly in the male. In our

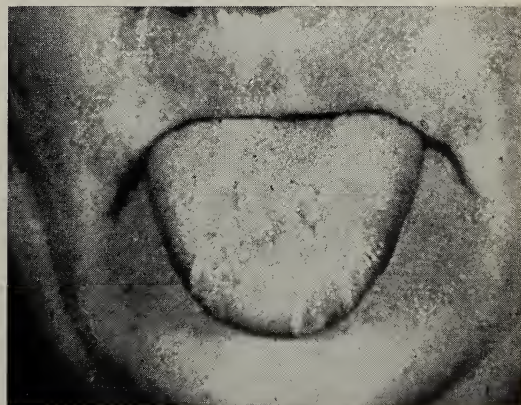


FIG. 1. Glossitis, due to vitamin deficiency.

series it occurs just about twice as often in the male as in the female.

(3) General appearance — Cancer of the tongue may assume different clinical characteristics. Figure 4 represents an example of a typical, comparatively early squamous cell carcinoma of the tongue. This had been present for approximately two months. Figure 5 shows one that is exophytic and possibly less malignant than the grossly infiltrating type. It is imperative that adequate inspection and palpation be carried out in order to determine the clinical features of a lesion anywhere on the tongue. A laryngeal mirror should be used to view the base of the tongue when indefinite symptoms are present. A gloved finger or a finger cot examination is also useful for evaluation of the base of the tongue. A tongue blade and flashlight examination is not adequate for the base because this part of the tongue is not visualized in this manner.

#### *Biopsy:*

Cancer should always be suspected in chronic ulcers or indurated areas in any part of the tongue. Specimens for biopsy should be taken without delay. There is no definite contraindication to biopsy. This is a simple procedure and may be accomplished within a few minutes at the time the patient is first seen. It is advisable to obtain the biopsy at the periphery



FIG. 2. *Leukoplakia on lateral aspect of the tongue. This is considered a premalignant lesion.*

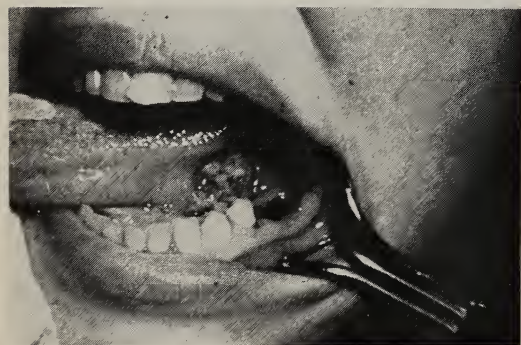


FIG. 3. *Cancer, lateral aspect of tongue in a 17-year old girl.*



FIG. 4. *Cancer of tongue. Comparatively early. This is most common location for this lesion.*



FIG. 5. *Cancer of tongue. Exophytic type.*

of the lesion so that the pathologist will have some impression of the infiltrating ability of the lesion. Bleeding can usually be controlled by pressure for a few minutes. Occasionally it is desirable to cauterize the biopsy site with a silver nitrate stick. Total excision of the lesion for biopsy is undesirable.

#### **Treatment**

The evaluation of treatment methods for tongue cancer and other head and neck cancers has vascillated from the early primitive surgical approaches to x-ray therapy, after its discovery at the turn of the century. With the advent of improved surgical modalities including endotracheal anesthesia, blood transfusion, and antibiotics, the surgical methods showed better treatment records in this country and x-ray therapy fell into some disfavor in the late 30's and 40's. The widespread availability of newer x-ray therapy methods (Cobalt, betatron and other varying radiation sources) in the past few years again influenced one's choice of method of treatment in the control of head and neck cancers. However, enough time has now elapsed to evaluate these efforts, and the supervoltage technics have not appreciably changed the end results over conventional therapy. The trend, therefore, has been especially reinforced by the finding that surgery is often not possible in recurrences following x-ray therapy. In



the instances wherein head and neck cancers have invaded bone (gingiva, palate), radiation necrosis of bone has been a distressing late problem if cancerocidal doses have been delivered.

The lesions in this series were treated by surgery when it was feasible. Those that were not surgically approachable were treated by irradiation. Radiation therapy was also used as an adjunct to surgery when the lesion could not be completely resected.

Surgical Management of Tongue Cancer

Small localized carcinomas of the anterior two thirds of the tongue are readily extirpated by partial glossectomy. If the lesion is in the tip of the tongue, this may be removed by a V-shaped resection which will restore a nearly normal tip. If it is located in the lateral aspect of the tongue, such as in Figure 4, this may be removed by a hemi-glossectomy, removing a generous elliptical portion of the tongue along the median raphe. Malignant lesions of the dorsum of the tongue are elliptically excised with an adequate margin surrounding the lesion. These defects are closed with interrupted silk sutures.

Well lateralized base of tongue carcinomas may be removed through an intra-oral approach by partial glossectomy. If the tonsillar pillar is involved, this is sacrificed to insure an adequate margin. If the lesions are more extensive and, especially if the mandible is involved, a partial mandibulectomy must be done with the partial glossectomy. This is usually combined with a radical neck dissection and will be described later. If the entire base of the tongue or the mid-portion of the base is involved, this may be resected and the middle third of the tongue sutured to the base of the epiglottis. Occasionally, a mid-base of tongue lesion extends to the base of the epiglottis so that it is necessary to combine a total laryngectomy with a partial glossectomy to eradicate the disease.

When the cervical lymph nodes contain metastasis, the treatment of choice is radical neck dissection. There is little difference of opinion regarding the management of cervical metastases, since curative doses of radiation to the entire neck is rarely pos-

sible. The most commonly involved nodes are found along the deep cervical chain. When a patient with carcinoma of the tongue presents with a node in the neck, the diagnosis is first established by aspiration biopsy. If the nodes are positive, the treatment of choice is a combined radical neck dissection plus resection of the primary lesion. If the primary lesions are in close proximity to the mandible, a portion of the mandible is resected with the tongue specimen. On the other hand, if the tongue lesion is not in close proximity to the mandible, it is possible to resect the primary lesion and the neck metastases in continuity without sacrificing the mandible.

There is some evidence<sup>2</sup> to indicate that a "prophylactic neck dissection" — performing a neck dissection even though cervical nodes cannot be palpated — is of value in improving the cure rate if performed at the time the primary lesion is excised. Since most of the failures are due to lack of control of neck metastases,<sup>3</sup> this is one measure to help reduce the number of failures.

TABLE 1. End Results

Total number of patients .....	162
Number qualifying for 5 year evaluation.....	89
Number living at the end of 5 years .....	29
Five-year survival rate — 32.5%	

Table 1 summarizes our experience and includes all cases, regardless of degree of involvement. Some were seen in consultation only and some died of other diseases before five years had elapsed. If allowances were made for these factors, the survival rate would be better than noted above.

Summary

The management of one hundred sixty-two (162) patients with cancer of the tongue is presented. The treatment was primarily by surgical resection. The absolute 5 year survival rate was 32.5 per cent for all lesions.

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**INSULIN-SECRETING TUMOR.** — Severe bouts of hypoglycemia occurred on two occasions, four years apart, in an elderly man and were relieved on each occasion by the removal of large retroperitoneal fibrosarcomas of the spindle cell variety. Homogenates of this tumor were found to possess large amounts of insulin-like activity as determined by its comparative ability to stimulate the conversion of labeled glucose into carbon dioxide and glycogen. The insulin-like activity of the tumor could be easily suppressed by a sulfhydryl inhibitor and by specific antibeef-insulin guinea-pig antibody. — Buris R. Boshell, M. D., J. J. Kirschenfeld, M. D., and Pete S. Soteres, Birmingham, Alabama, *The New England Journal of Medicine*, 270:338-341, Feb. 13, 1964.

# Infectious Mononucleosis Meningo-Encephalitis

## Report of Two Cases

DAVID F. SCHAEFER, M.D.

THE relatively infrequent occurrence of significant central nervous system complications in infectious mononucleosis prompted the recording of the following cases.

Case 1. An 18 year old U.S. Army private was admitted to the U.S. Naval Hospital, Chelsea, with a four day history of nausea, anorexia, headache, and unsteady gait. On the day prior to admission, he had vomited six or seven times. Three weeks prior to admission he had been treated for one week at another military hospital for bronchopneumonia. One week prior to admission, he noted the onset of a sore throat and treatment was started with injections of procaine penicillin and oral oxytetracycline. This medication was continued until the time of admission to this hospital.

His paternal grandfather and uncle had diabetes. Past history and review of systems were entirely negative.

On admission, the patient's temperature, pulse, respiratory rate, and blood pressure were normal. His pupils reacted to light and accommodation, and no papilledema or nystagmus were noted. The tonsils were injected and there was a patch of grey exudate on the left. The lungs and heart were normal to examination. The liver was palpable 1 fingerbreadth below the right costal margin in the mid-clavicular line. Diffuse lymphadenopathy of a moderate degree was noted, but no splenomegaly was apparent. The cranial nerves were intact. Muscle tone and strength were normal and sensory modalities were intact. His gait was wide-based, and he tended to fall to the left. There was no dysmetria with finger-to-nose and heel-to-shin testing. Deep tendon reflexes were equal and brisk bilaterally. No pathologic reflexes were elicited.

Laboratory data revealed a white blood cell count of 11,450 per cubic millimeter with 69 per cent lymphocytes of which approximately 8 per cent were atypical. The latter showed staining and morphology similar to that reported in infectious mononucleosis. Hemoglobin was 15 Gm./100 ml. Serum electrolytes, fasting blood sugar, and blood urea nitrogen were normal. Bromsulfalein retention was 10 per cent in 45 minutes; cephalin flocculation, 4 plus at 48 hours; and alkaline phosphatase, 5.0 Bodansky units. Absorbed heterophile antibody titer was 1:3584. The cerebrospinal fluid was under normal pressure and contained 40 lymphocytes, 2 polymorphonuclear cells, and 5 red blood cells per cu. mm. No growth was noted on routine culture of the spinal fluid. The spinal fluid protein was 38 mg/100 ml. Heterophile antibody titer was not demonstrated.<sup>1</sup> Chest and skull x-rays were normal. An electroencephalogram was interpreted as mildly and diffusely abnormal, without focal abnormalities or seizure pattern.

Persistent vomiting necessitated intravenous fluid administration. Splenomegaly and an increase in hepatomegaly were apparent on the second hospital day. Dysarthria developed, and ataxia progressed so that he was unable to

### *The Author*

● Dr. Schaefer, Defiance, is a member of the staff, Internal Medicine, at Defiance Hospital; formerly, Lt. Comdr. MC in the U.S. Navy, on active duty stationed at U.S. Naval Hospital, Chelsea, Massachusetts, until August, 1964. Dr. Schaefer's residency in Internal Medicine, 1958-1961, also was spent at the U.S. Naval Hospital in Chelsea.

walk or stand. Marked dysmetria on finger-to-nose and heel-to-shin testing, truncal ataxia, and nystagmus toward the right were evident. At no time did nuchal rigidity develop, nor did Kernig's or Brudzinski's signs become positive. The deep tendon reflexes remained active and equal and the plantar reflexes remained extensor bilaterally.

On the fifth hospital day, parenteral corticosteroid therapy was begun. After two days, the vomiting had ceased and oral administration of prednisone was continued in gradually decreasing dosage over the next nine days, at which time it was discontinued. No marked change in the ataxia was noted concomitant with the steroid administration, but it was felt that no further progression of the ataxia was evident. The cerebrospinal fluid on the ninth hospital day showed 6 lymphocytes/cu.mm. The hepatosplenomegaly and lymphadenopathy had regressed by the thirteenth hospital day. At that time the white blood count was 13,250 with 75 per cent polymorphonuclear cells and 25 per cent lymphocytes of which none were considered atypical. Absorbed heterophile antibody titer was 1:856.

On the sixteenth hospital day, at the time when the steroids were discontinued, the total serum bilirubin was 0.6 mg/100 ml.; cephalin flocculation, 3 plus at 48 hours; thymol turbidity, 7 units; serum protein, 6.4 Gm./100 ml.; and albumin 4.3 Gm./100 ml. During the second week in the hospital, gradual and continual improvements in the ataxia became evident, and by the thirtieth hospital day, only the wide-based gait remained. This improved, and subsequent neurologic examinations were normal. He remained asymptomatic on full activity. On the fifty-fourth hospital day, he was discharged to return to full active military duty.

Case 2. A 20 year old U.S. Navy seaman was admitted to a local military dispensary with complaints of a cold and slight headache. Symptomatic therapy was prescribed. On the second day, he experienced a grand mal convulsive seizure. He was transferred to the U.S. Naval Hospital, Chelsea. He had several more seizures enroute and in the admission room after arrival, in spite of having received amobarbital sodium 250 mg. and diphenylhydantoin sodium 250 mg. intravenously.

The patient's temperature was 100°F rectally; pulse rate, 140/minute; blood pressure, 138/82; respiratory rate,

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The opinions and assertions contained within this paper are the private ones of the writer and are not to be construed as official or reflecting the views of the Bureau of Medicine and Surgery or the naval service at large.



20/minute. He was unresponsive to painful stimulation. The pupils were reactive to light, and there was no papilledema. The nasal and pharyngeal mucosa was injected, but without exudate. No rigidity was apparent. The lungs were clear, and the heart revealed only tachycardia. No abdominal organs or masses could be palpated. The deep tendon reflexes were hyperactive without lateralization, and the plantar reflexes were alternately flexor and extensor.

Laboratory data revealed a white blood cell count of 18,600/cu. mm. with 71 per cent lymphocytes of which approximately 80 per cent were atypical. Hemoglobin was 16.7 Gm./100 ml.; hematocrit 49 volumes per cent; and blood urea nitrogen, 11 mg/100 ml. Blood sugar and serum electrolytes were within normal limits. Chest and skull x-rays were normal. Lumbar puncture was done shortly after admission, and the cerebrospinal fluid contained 37 lymphocytes. No organisms were seen on Gram stain, and no growth was noted on routine culture. The spinal fluid protein was 320 mg/100 ml., and the Pandy reaction was positive. Absorbed heterophile antibody titer was 1:57,344. Serum glutamic pyruvic transaminase was 77 units; bilirubin, 0.70 mg/100 ml.; thymol turbidity, 7 units, cephalin flocculation, 4 plus at 48 hours; bromsulphalein retention, 4.0 per cent in 45 minutes; and prothrombin time, 17 seconds with control of 12 seconds. On the day after admission, the lumbar puncture was repeated. The opening pressure was 220 mm. water. The cerebrospinal fluid contained 19 lymphocytes/cu.mm.; protein, 228 mg/100 ml.; and the colloidal gold curve, 5444444332.

After the seizures were controlled, he remained deeply stuporous for two days and markedly obtunded and disoriented until the fifth hospital day, at which time his sensorium cleared. On the day after admission, his rectal temperature was 103°F. Splenomegaly and lymphadenopathy were noted for the first time. He was given no therapy other than intravenous fluids and anticonvulsants in the form of phenobarbital and diphenylhydantoin. By the fifth hospital day, he was afebrile. The neurologic examination was normal and oral fluids and a soft diet were tolerated. On the ninth hospital day, the cerebrospinal fluid was under normal pressure; the protein was 168 mg/100 ml.; colloidal gold curve, 1111221100; cell count, 8 lymphocytes; and heterophile antibody titer was 1 plus positive.<sup>1</sup>

An electroencephalogram done on the seventeenth hospital day revealed a moderately generalized abnormal record with mild activation by hyperventilation. Because of the clinical impression that he was intellectually obtunded, a Wechsler Adult Intelligence Scale and a Bender-Gestalt were obtained on the fourteenth hospital day and were interpreted as being consistent with at least average intelligence and not suggestive of specific indices of intracranial pathology, but these did suggest difficulties with abstract conceptualization and immediate recall and a slowness of intellectual manipulation.

His improvement was very slow. By the end of the eighth week in the hospital, the splenomegaly had regressed although generalized lymphadenopathy was still quite prominent. Absorbed heterophile antibody titer was 1:224. The serum transaminase, prothrombin time, and thymol turbidity were normal, but the cephalin flocculation was still 4 plus at that time. At this point, his mother assured the staff that his intellectual functioning was similar to that prior to his illness. He was placed in an ambulatory convalescent status from the eighth week onward. He persisted in the complaint of easy fatigability until about the twelfth week of his illness. At that time his electroencephalogram had improved and was felt to be only mildly and diffusely abnormal; absorbed heterophile antibody titer was 1:56; and white blood cell count was 7150/cu.mm. with 45 per cent lymphocytes of which a few were atypical.

One hundred and sixteen days after the onset of his illness he was returned to full active military duty. At the time of his discharge, he was entirely asymptomatic and physical examination was entirely normal except for minor persistent lymphadenopathy.

## Discussion

Neurologic complications occur in less than 1 per cent of cases of infectious mononucleosis.<sup>2</sup> Although the overall mortality rate in infectious mononucleosis is less than 1 per cent, mortality rates between 10 and 20 per cent have been reported<sup>3</sup> when the nervous system is involved. When only those cases with neuronitis (Guillain-Barre-Strohl syndrome) are considered, the mortality rate may be as high as 25 per cent.<sup>4</sup>

Both of the cases presented here can be categorized as examples of meningo-encephalitis due to infectious mononucleosis in the classification of Bernstein and Wolff.<sup>2</sup> The first case, which presented with acute cerebellar ataxia, represents an exceedingly rare manifestation of central nervous system involvement in infectious mononucleosis.<sup>5,6,7</sup> Bennett and Peters felt that their case, reported in 1961, was only the third case recorded of acute cerebellar ataxia due to infectious mononucleosis in an adult.<sup>7</sup> Primary encephalitic involvement as exemplified by the second case is also reported quite rarely.<sup>2,8,9</sup> The second case demonstrated how acutely the illness may present, and the prolonged course and protracted incapacitation often associated with infectious mononucleosis.

In both instances, the diagnosis was established quickly, being suggested by the initial differential white blood cell count and the lymphocytes in the cerebrospinal fluid. Each was corroborated by the elevated absorbed heterophile antibody titers using the Davidsohn method.

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**GUANETHIDINE**—Three cases are described in which "collagen vascular disease" developed during treatment of long-standing hypertension with guanethidine. They presented as mononeuritis multiplex, polyarteritis nodosa, and cerebral vasculitis respectively.—H. A. DeWar, M.D., and M. J. T. Peaston, M.B., CH.B., *British Medical Journal*, vol. 2, 609-611, September 5, 1964.

# Uterine Myomas Affecting Urinary Drainage

M. BALUCANI, M.D., E. C. ROST, M.D., and F. M. DOUGLASS, M.D.†

DILATATION of one or both ureters during pregnancy has been known since 1924.<sup>10</sup> In 1928 Duncan and Seng<sup>2</sup> demonstrated right ureteral dilatation in 78 normal pregnant women by intravenous pyelographic study. Eastman,<sup>3</sup> in 1955, stated that dilatation of the right ureter is two to three times more frequent than dilatation of the left during pregnancy because of dextrorotation of the pregnant uterus. Hundley<sup>8</sup> et al, in 1938, attributed the greater dilatation on the right side to the fact that the left ureter is protected by the overlying sigmoid flexure and also that the right ureter crosses the iliac vessels at nearly a right angle whereas the left runs almost parallel to them.

A hormonal influence as etiopathogenesis of ureteral dilatation has been taken into consideration by many authors throughout the world. Hundley and Diehl<sup>9</sup> in 1945 noted an increase in peristalsis under stilbestrol administration for 10 days. The "physiological hydroureter" of Saitz,<sup>14</sup> 1931, due to a "corpus luteum hormone stimulation" still is a well accepted theory. Philipp,<sup>13</sup> in 1937, sought to prove that hormones of the placenta may cause distention of the ureters in nonpregnant women. Bompiani,<sup>1</sup> in 1933, reported on inhibition of peristalsis in isolated animal ureters with corpus luteum extract. The pathologic finding in the dilated ureter of pregnancy consists of marked hypertrophy of the sheath of Waldeyer (Hundley et al, 1938).<sup>8</sup> It appears that dilatation of the ureters in pregnancy is due to hypotonia, edema, and hypertrophy of the ureteral wall caused by hormonal imbalance; the mechanical factor seems to be of secondary importance (T. Fainstat 1963).<sup>7</sup>

It is widely held that any bilateral dilatation of the ureters with symptoms of chronic renal insufficiency, found in a nonpregnant woman, almost always is due to a malignancy of the genital tract. The purpose of this communication is to recall one of the common benign causes of this condition.

## Report of a Case

A 48 year old Negro woman, Gravida III, Para III, was admitted because of vaginal bleeding of one month's dura-

## The Authors

- Dr. Balucani, Toledo, is Chief Resident, Obstetrics and Gynecology, Maumee Valley Hospital.
- Dr. Rost, is Chief of Obstetrics and Gynecology, Maumee Valley Hospital.
- Dr. Douglass (deceased)†, former Director of Surgery, Maumee Valley Hospital, Toledo.

tion. There were no symptoms related to other organs. The menstrual history was normal with catamenia at the age of 14 and regular periods on a 28 day cycle and five days flow until one month previously. Medical history was essentially negative, and there was no previous surgery. Her past history was noncontributory.

*Physical examination* revealed a well developed, well nourished Negro woman. She was pale but was in no acute distress. Blood pressure was 160/100, pulse rate 86 per minute. The abdomen was normal in size and shape. A hard, smooth, fixed, and nontender mass was felt one finger breadth above the symphysis pubis. The liver was one finger breadth below the arch, normal in consistency and nontender. The spleen was not palpable.

Pelvic examination showed normal external genitalia with a marital introitus and a good anterior and posterior vaginal wall. The cervix was multiparous. The os was closed, with dark blood coming from it. The uterus was enlarged, smooth, hard, and fixed, and it was difficult to evaluate the adnexae. Rectal examination revealed a normal rectum with a normal mucosa. The cul-de-sac was filled with a hard, fixed mass in continuity with the mass previously felt by vagina. Complete physical examination revealed no other significant findings, and a diagnosis of secondary anemia due to a blood loss from uterine fibroma was made.

*Laboratory Data:* White blood cell count was 8,300, red blood cell count 2,690,000, hemoglobin 5.7 Gm., and hematocrit 19 per cent. Differential count was normal. Urinalysis revealed slightly cloudy urine with a specific gravity of 1.009; pH 5.5; white blood cells 0-2 per high power field, rare red blood cells, no casts, protein 143 mg. per 100 ml., and no sugar. Blood urea nitrogen was 104 mg/100 ml with creatinine 12.5 mg/100 ml. Serum electrolytes were reported as follows: phosphorus 2.1 mg/100 ml, sodium 142 mEq/L, potassium 3.9 mEq/L, chloride 107 mEq/L, and CO<sub>2</sub> 13 mEq/L. The blood pH was 7.291 and pCO<sub>2</sub> 26. X-ray films of the abdomen showed a soft density in the pelvis. The chest x-ray was essentially normal.

With these laboratory reports, an emergency cystoscopic examination was done. An extrinsic mass was found to be compressing the greater portion of the bladder. Catheterization of the left ureter was impossible because of complete obstruction encountered 8 cm. from the meatus. The right ureter also was obstructed at 8 cm. but a No. 5 catheter was passed above the obstruction with great difficulty. Urine flow from this catheter was at a rate of 10 cc. per hour.

The patient received 2 units of packed red blood cells

From the Department of Obstetrics and Gynecology, and the Department of Surgery, Maumee Valley Hospital, Toledo, Ohio. Submitted January 20, 1965.

†Dr. Douglass died March 23, 1965.



and 4000 cc. of fluid (5 per cent dextrose in water) plus sodium bicarbonate with potassium chloride to correct the anemia, azotemia, and metabolic acidosis in the first 48 hours. After this treatment, the picture of renal insufficiency appeared to be improved. The blood urea nitrogen decreased to 88 mg/100 ml and creatinine to 11.2. Hemoglobin rose to 7.9 and hematocrit to 23. The blood pH was 7.351, CO<sub>2</sub> 14, and pCO<sub>2</sub> 25, with other electrolytes within normal range. An isotope renogram showed a decreased excretory phase with almost flat curve.

The case was presented to the staff as one of bilateral ureteral obstruction, anemia, azotemia, chronic pyelonephritis, and metabolic acidosis due to uterine fibroma. Because of the persistent azotemia, a semi-emergency laparotomy was performed, and a large fibroma below the pelvic brim was found compressing both ureters. Total hysterectomy and bilateral salpingectomy was performed.

The patient had a satisfactory postoperative course. The blood urea nitrogen decreased to 54 mg/100 ml and creatinine to 4.1 mg/100 ml, with normal serum electrolytes. A repeat isotope renogram revealed no change from the curve obtained before surgery. The patient was transferred to the Medical Service on the twelfth postoperative day because of myocardial infarction. She died three months later of another myocardial infarction.

A search of the American literature was carried out to find out how often a uterine fibroma was the cause of such extensive damage to the urinary tract. Drs. Kretschmer and Kanter (1937)<sup>10</sup> investigated, by pyelographic study, a group of nonpregnant women who were suffering from various lesions of the gynecological tract to see how often the upper urinary tract was involved. In this group there were 35 cases of fibromas, as shown in Table 1.

TABLE 1. Results from a study in the series by Drs. Kretschmer and Kanter

35 cases of fibromas with pyelographic study showing urinary tract involvement	
24 fibromas were above the pelvic brim of the 24:	11 fibromas were below the pelvic brim of the 11:
16.4% bilateral dilatation and unilateral displacement of the ureters	50% unilateral dilatation of the ureters
16.4% bilateral dilatation of the ureters	
11.6% unilateral dilatation with lateral displacement of the ureters	16.6% unilateral dilatation and unilateral displacement of the ureters
35.2% unilateral right side dilatation of the ureters	
5.8% bilateral dilatation and bilateral displacement of the ureters	23.2% bilateral dilatation of the ureters
11.6% only displacement of the ureters	

None of their patients had a semi-emergency condition similar to our patient. Everett and Sturgis<sup>1</sup> in 1940 found 66.6 per cent of upper urinary dilatation in 30 patients with large myomas. In patients with smaller tumors, 29.4 per cent showed such dilatation. Again, Everett and Scott<sup>5</sup> found in 17 uterine fibroids above the pelvic brim without salpingitis, 35.3 per cent bilateral dilatation and 23.5 per cent unilateral dilatation. In nine fibroids below the pelvic brim without salpingitis, they found 11.1 per cent bilateral dilatation and 22.2 per cent unilateral dilatation.

Everett<sup>6</sup> states that the dilatation of the upper urinary tracts was completely asymptomatic, except for one patient who had left renal colic caused by hydronephrosis resulting from a large myoma.

A study of all uterine fibromas, not including private patients, operated at our hospital from April 1, 1954 to March 31, 1964 was done to determine the incidence of fibromyomata and upper urinary involvement. In this period 79 total hysterectomies for myomas of the uterus were performed. Seventy-two patients (91.1 per cent) had intravenous pyelographic studies before surgery.

The result of our investigation is reported in Table 2.

TABLE 2. Results from a study in Maumee Valley Hospital Series, April 1, 1954, to March 31, 1964.

Total number of patients reviewed -- 79 72 patients had preoperative pyelographic study Weight of the fibromas was from 250 Gm. to 4,400 Gm.		
32 fibromas	10 had urinary involvement (31.1%)	3 had bowel involvement
were	5 with R. ureteral dilatation (40%)	
above the	1 with R. dilatation plus left displacement (10%)	1 acute small bowel obstruction (33.3%)
pelvic	3 left ureteral dilatation (30%)	
brim	2 bladder compression (20%)	2 large bowel compression (66.6%)
	12 had urinary involvement	
47 fibromas	1 with bilateral dilatation of the ureters (case report) (14.2%)	
were	1 bilateral dilatation of the ureters (Fig. 1) (14.2%)	
below the	2 R ureteral dilatation (Fig. 2) (28.4%)	
pelvic	1 L dilatation plus bladder compression (14.2%)	
brim	7 had bladder compression (28.4%)	

Discussion

In our study, urinary complications are less frequent than in those of the previous authors. It would appear that since 1939 there has been a reduction in the urinary sequelae from uterine fibromas, perhaps due to earlier diagnosis and prompt corrective measures. In our cases, we found a high incidence of bilateral ureteral dilatation in the myomas below the pelvic brim, 28.4 per cent. In these patients the uterine enlargement was symmetrical, forcing the uterus inside the pelvis, causing a mechanical obstruction of both ureters.

In instances of unilateral ureteral dilatation, we encountered a cervical or intraligamentous fibroma

located on the same side of the obstruction. To avoid injury of the ureter, its isolation was necessary during surgery. Chronic unilateral pyelonephritis was almost a routine finding. One patient (see case history) showed an acute renal insufficiency due to



FIG. 1. Pyelographic study of one of the four patients with right dilatation. At laparotomy a uterine fibroma above the pelvic brim was found.

prolonged bilateral obstruction and chronic pyelonephritis.

In the myomas above the pelvic brim we have seen no bilateral dilatation. We cannot explain this finding except as a coincidence. Kretschmer and Kanter<sup>10</sup> state that the fibroid growing out of the pelvis

is less prone to produce ureteral compression because of possibility of a free space between the tumor and the pelvic brim. In the cases of unilateral dilatation, we found that the location of the fibroma was such that it was adherent to the parietal peritoneum and therefore, impinging against the bony pelvis overlying the ureter. How much superimposed periureteritis contributes to the dilatation is hard to determine. From the follow-up of Drs. Kretschmer and Kanter it appears that when renal damage is present, once the "primum movens" is removed, a prompt return to normal is obtained. Drs. Kretschmer and Kanter did not have any patient with severe renal damage. In our patient during the three months follow-up, persistent chronic pyelonephritis was present.

No mention is made by the previous authors about the possibility of acute bowel obstruction due to a



FIG. 2. Case of bilateral ureteral dilatation. At laparotomy a uterine fibroma below the pelvic brim was found.

fibroma. This eventuality exists and has to be kept in mind. Large bowel compression can be easily recognized and differentiation from an intrinsic colon lesion should not be difficult.<sup>12</sup>

Conclusion

Renal failure due to obstruction of both ureters by uterine myoma is rare, but it does exist, especially in ureteral compression of long standing. Such a case is reported. Partial compression of the upper

TABLE 3. Comparison of the Statistics

Fibromas above the pelvic brim		Fibromas below the pelvic brim
24 cases with 70.8% urinary involvement	Kretschmer's and Kanter's series 35 cases	11 cases with 54.5% of urinary involvement
30 cases of large myomas—66% with urinary involvement	Everett's and Sturgis's series 30 cases (?)	? smaller fibromas with 29.4% of urinary involvement
17 cases with 58.8% urinary involvement	Everett's and Scott's series 26 cases	9 cases with 33.3% urinary involvement
32 cases with 31.1% urinary involvement 9.5% bowel involvement	Maumee Valley Hospital's series 79 cases	47 cases with 14.8% urinary involvement



urinary tract due to a fibroma of the uterus is a well proved clinical entity, which sometimes is forgotten because of its more common association with genital tract malignancy. We believe that pyelographic studies should be a routine diagnostic evaluation in a gynecological patient. The surgical treatment is total hysterectomy with bilateral salpingectomy. The ovaries should be saved whenever possible. Myomectomy should be reserved for the young patient in whom the family has not been completed. To the above surgical correction, it is necessary to add pre-operative and postoperative medical control of cystitis, pyelitis, and pyelonephritis.

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POSTLUMBAR PUNCTURE HEADACHE. — This study was prompted by the observation that patients with demyelinating disease undergoing multiple lumbar punctures with intrathecal instillations of methylprednisolone acetate rarely complained of postlumbar puncture symptoms. Two hundred patients undergoing routine lumbar puncture were assigned in rotation to four treatment groups according to the order of their admission to the acute neurology service. The punctures were performed with a No. 18 gauge needle; in three groups, saline, methylprednisolone acetate, or polyglycol vehicle was then instilled, as outlined below. After the needle was removed the patient was allowed out of bed ad libitum, and all patients were assured that they would have no symptoms following lumbar puncture. No patients were aware that they were receiving any injection beyond the routine lumbar puncture. When the patients were examined 8 to 24 hours after puncture, none had pain on neck flexion or straight leg raising. Almost all had some discomfort in the area of the needle puncture, but this was slight. The incidence of headache was as follows:

Treatment	No. Males	No. Females	Ave. Age	Incidence of Headache
Group 1 — 10 cc. 0.9% saline .....	25	25	52 yrs.	45%
Group 2 — 40 mg. methylprednisolone acetate with polyglycol vehicle in 10 cc. 0.9% saline .....	24	26	47	4%
Group 3 — 1 cc. polyglycol vehicle in 10 cc. 0.9% saline .....	24	26	50	42%
Group 4 — no injection (routine puncture only).....	26	24	47	38%

The incidence of headache in group 4 is comparable to that found in the literature, while that for groups 1 and 3 is slightly higher. The neurological diagnoses were varied, and there was no evident preponderance of a single diagnostic category in any group. The author has tried to treat postlumbar puncture headache with methylprednisolone acetate in a few cases, without any success. The drug appears to be of substantial clinical value, however, in prevention of symptoms following lumbar punctures.

There were no complications of any kind following intrathecal instillation of methylprednisolone in this series, despite a few traumatic lumbar punctures and some multiple punctures. A few patients with demyelinating disease receiving multiple injections of methylprednisolone acetate have had pleocytosis in subsequent cerebrospinal fluid examinations. — (ABSTRACT), Stephen A. Kulick, M. D.: *Journal of the Mount Sinai Hospital, New York*, 32:75-78 (January-February) 1965.

# Multiple Primary Malignant Tumors

## Coexistence of Squamous Cell Bronchogenic Carcinoma and Lymphoblastic Lymphoblastoma — A Case Report

JOHN CARPATHIOS, M.D., WILLIAM BOGEDAIN, M.D., HUSSEIN SARIKAYA, M.D.,  
and ALAN RAFTERY, M.D.

**M**ULTIPLE primary malignant tumors in one or different organs have been reported,<sup>1, 2, 4, 5</sup> but the true incidence of such coexistence may be higher than the literature indicates. A second malignant tumor in the same individual is often taken as metastatic disease. The possibility of a second primary lesion is seldom suspected or adequately investigated. This may account, in some cases, for the poor results from treatment of cancer of the lung. What we consider, without search, as recurrence, extension, or metastasis, may represent development of a new primary neoplasm.<sup>6</sup> The time interval after the original operation, the gross morphology and the microscopic histologic picture, will be important criteria in excluding the metastatic nature of the new lesion.<sup>1</sup>

Invasive carcinoma arising from bronchial mucosa distant to the original site, without lymphatic or parenchymal involvement, speaks for a new primary lesion. The diagnosis of such a new primary malignancy is of great practical value. Resectional surgery may afford the patient renewed hope for cure in an apparently hopeless situation.

In lung cancer particularly, with the present popularity of lobectomy as the operation of choice in a significant percentage of cases, additional surgery (eg, ipsilateral pneumonectomy or contralateral lobectomy) as determined by the extent and location of the new primary lesion may be feasible and curative. The occurrence of a lesion which belongs histologically to a completely different pattern and classification establishes beyond doubt the coexistence of multiple primary tumors in one individual. Multiple primary carcinomas of the lung are unusual. Coexistence of squamous cell carcinoma and lymphoblastic lymphoblastoma is extremely rare. We present such a case in this paper.

### Case Report

A 53 year old white man was admitted to Mercy Hospital, Canton, Ohio on November 26, 1961. He gave a history of recurrent respiratory infections, chronic moderately productive cough, and a recent episode of hemoptysis.

The most important finding on physical examination was

### The Authors

- Dr. Carpathios, Canton, is active member of staff in Thoracic Surgery, Mercy, and Timken Mercy Hospitals.
- Dr. Bogedain, Canton, is chief of staff, Mercy, and Timken Mercy Hospitals.
- Dr. Sarikaya, Canton, is Associate Director of Laboratory, Timken Mercy Hospital.
- Dr. Raftery, Canton, is Director of Laboratories, Timken Mercy Hospital.

the palpation of lymph nodes in both axillae, particularly on the left and also in the right supraclavicular (scalene) area.

A chest x-ray revealed a cavitory lesion in the left lower lobe with an air-fluid level (Fig. 1).

Laboratory findings were essentially within normal limits, except for a white blood cell count of 20,150 with a normal differential count.

Bronchoscopic examination failed to reveal intraluminal obstruction or tumor. Cytologic examination of the bronchial washings, however, revealed malignant cells. Scalene and

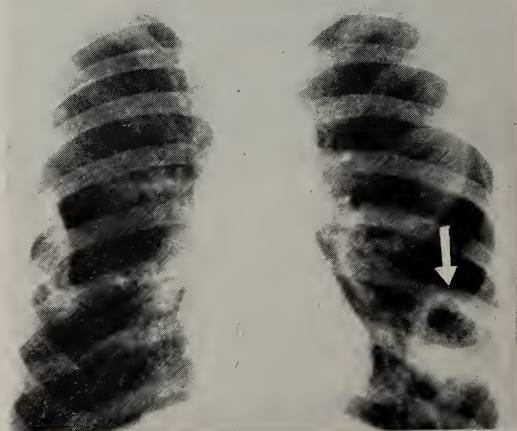


FIG. 1. Cavitory Lesion in left lower lobe. Density of right lateral chest wall is due to old healed fracture deformities of fifth, sixth, seventh, and eighth ribs.

Submitted January 29, 1965.



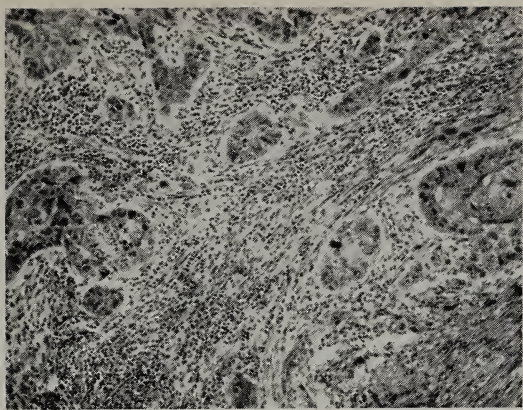


FIG. 2. Sections of the tumor mass (left lower lobe) show it to be composed of a relatively thick wall of connective tissue diffusely invaded by sheets of hyperchromatic squamous epithelial cells with nuclear enlargement and variation. (Squamous cell Carcinoma.)

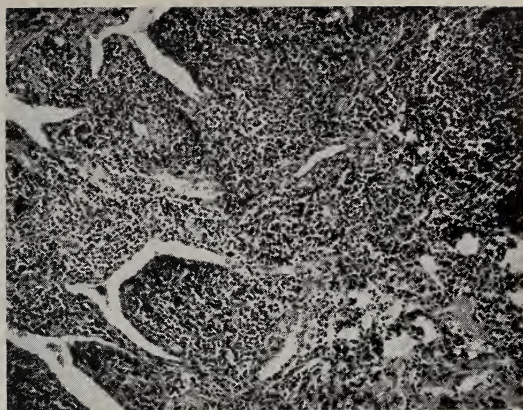


FIG. 3. Sections of hilar (mediastinal) lymph nodes replaced by sheets of relatively uniform, hyperchromatic lymphocytic and lymphoblastic cells, with complete loss of normal architecture. (Lymphoblastic lymphoblastoma.)

axillary node biopsies were carried out establishing the diagnosis of lymphoblastic lymphoblastoma in these structures.

A left thoracotomy was performed on December 7, 1961. Extirpation of the lesion was effected by a left lower lobectomy. A few hilar nodes were also included in the specimen. The main lesion, centrally excavated (central necrosis), proved to be squamous cell carcinoma (Fig. 2). The hilar nodes were completely different histologically, representing lymphoblastic lymphoblastoma (Fig. 3).

Our patient was treated, after his surgery, with a series of nitrogen mustard injections (0.1 mg. per Kg. of body weight daily for four days). He was subsequently started on long term therapy with Cytoxan® 100 mg. daily by mouth.

Three years after his lobectomy, the patient is in good condition, in spite of the presence of some enlarged nodes in the axillae and groins. The future of the patient is unknown, but the combination of pulmonary resectional surgery and systemic chemotherapy has so far given us gratifying results.

### Conclusions

1. The possibility of multiple primary malignant tumors in the lung should be kept in mind and properly investigated.

2. Additional resectional, "curative" surgery may become feasible once the primary nature of the new lesion is established.

3. An unusual and interesting case of squamous cell carcinoma and lymphoblastic lymphosarcoma, successfully managed by resectional surgery and chemotherapy, is reported.

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**P**ATHOLOGIC MALINGERING is a definite clinical entity, involving severe pain and disability. When manifested in the extremity, it lends itself to ready separation from other diseases in which motivation is not an etiologic factor. Removal of the motivation to maintain disablement must be accomplished before other therapy can be effective. Usually, the motive is financial and has its roots in the social and legal system. The key to solution of this complex social problem lies in the consistent recognition of pathologic malingering by the medical profession. — Robert S. Shaw, M. D., Boston: "Pathologic Malingering. The Painful Disabled Extremity," *The New England Journal of Medicine*, 271:22-26, July 2, 1964.

**NOTE:** All physicians are urged to read this excellent article for a better understanding of the perplexing and frustrating problem of Malingering. — THE EDITOR.

# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

C. R. MACPHERSON, M. D., *President*

**D**R. RUPPERT: For our conference today we are taking a different approach. Our discussant and our attending faculty did not see the protocol until they entered the room. Dr. Weissler, our discussant, will therefore have to read the protocol, consider it, and ask the opinion of various consultants in the audience as he discusses it. We hope this exercise will allow the students a better insight into the problem-solving process in clinical medicine.

## CLINICAL DISCUSSION

**DR. WEISSLER:** This 42 year old white woman was admitted with a chief complaint of swelling of her abdomen and legs. She had been treated intermittently for hyperthyroidism for about 25 years. The patient stated that for the past 18 months she had been too weak to do her housework. Seven months prior to admission she had an episode of swelling of her abdomen and legs which was accompanied by shortness of breath. This lasted approximately three weeks and subsided spontaneously. She received no medication during this time. The edema and shortness of breath recurred about one week prior to admission. Her family physician referred her to University Hospital. During the past 18 months the patient had had episodes of severe nervousness, weight loss, and four to six soft-formed stools per day. Review of systems and past medical history were noncontributory.

We might pause here and ask, How valid is the history of recurrent hyperthyroidism? Is there good evidence in the history that she indeed did have hyperthyroidism on and off for the past 25 years, Dr. Ruppert?

**DR. RUPPERT:** We had no laboratory studies prior to her admission to the hospital.

**DR. WEISSLER:** Weight loss occurred despite the fact that she developed edema, a fact which I think is rather important. Patients who develop edema usually gain weight, and when such a patient loses

## *Presented by*

- Arnold M. Weissler, M.D., Columbus, and
  - Dante G. Scarpelli, M.D., Ph.D., Columbus.
- Edited by Dr. Scarpelli.

weight one must look for an independent process other than congestive heart failure for the explanation.

She was a thin white woman appearing somewhat agitated, with a blood pressure of 190/92. The pulse pressure was wide and the diastolic pressure high. This differs from the usual hemodynamic picture in hyperthyroidism, where the pulse pressure is wide and the diastolic pressure is relatively low. A diastolic of 92 suggests that she might have been hypertensive. Her pulse was 200. The extremely rapid tachycardia might also account for the high diastolic pressure. The arterial pulse pressure is usually quite narrow at such a fast heart rate. The data therefore suggest that despite tachycardia she maintained a high stroke volume. The overall response is that of a markedly hyperdynamic circulation. The respirations were 30 and the temperature 100.5°. There was bilateral exophthalmos. The discs were flat and there was no evidence of arteriosclerotic change of the retinal vessels.

## Thyroid Bruit or Venous Hum?

The thyroid gland was diffusely enlarged and had bruit over it. This point deserves some clarification. Did this patient really have a bruit over the gland or did she have a venous hum that was being heard along the thyroid? Most patients who have an enlarged thyroid and hyperthyroidism have a systolic or diastolic bruit over this area. If one carefully examines the supraclavicular area he finds that these sounds may not emanate from the thyroid gland but indeed reflect hyperdynamic flow in the veins of the neck. Many people have venous hums without having hyperthyroidism, so the differentiation of the



venous hum from a thyroid bruit is more than just of academic importance.

DR. GWINUP: Is there any way you can tell them apart aside from the location?

DR. WEISSLER: If one presses high on the neck of a patient with a venous hum, the hum will usually disappear or diminish, but not the thyroid bruit. Flexing and extending the neck is also helpful; if the bruit changes abruptly with altered position, it is probably a venous hum. I would have liked to know this since the presence of a true thyroid bruit reinforces the diagnosis of hyperthyroidism; the venous hum in addition to a thyroid bruit reflects the hyperdynamic circulation associated with thyrotoxicosis.

There was slight dullness to percussion at both bases with decreased breath sounds at the right base. Nothing is said about egophony or fremitus changes through which at the bedside we can usually confirm pleural fluid. Râles were heard throughout both lung fields. The kind of râles is not described. I will assume they were inspiratory moist râles. The heart had irregular rhythm. The point of maximal impulse was in the left anterior axillary line. So we have a large heart that was beating irregularly at a rate of 200 with a wide pulse pressure, and we are told there was a Grade III/VI pansystolic ejection murmur.

### Precordial Sounds

DR. RUPPERT: Would you comment on the pansystolic ejection murmur?

DR. WEISSLER: A pansystolic murmur is one that begins with the first heart sound and ends with the second heart sound. An ejection murmur is one that begins about .04 to .06 second after the first heart sound, rises to a peak in mid-systole and usually ends with, or just before, the second sound. There is usually a period of silence between the first sound and the beginning of the ejection murmur. I become concerned, Dr. Ruppert, with the accuracy of the observation when one calls an ejection murmur pansystolic. I would like to know whether she had other adventitious cardiac sounds. Patients with hyperthyroidism have other precordial and cardiac sounds of importance, a result of their hyperdynamic circulation. We mentioned the venous hum. They have systolic scratchy sounds along the left sternal border—the Lerman-Means sign.<sup>1</sup> They may exhibit several types of murmurs, systolic regurgitant and ejection types, and they may actually have a diastolic rumble that sounds much like mitral stenosis. They often exhibit loud third or fourth heart sounds.

DR. PERKINS: Dr. Weissler, in the face of a pulse of 200, isn't it rather difficult to hear the murmurs?

DR. WEISSLER: I would agree that the extreme tachycardia would hinder auscultation and diminish

the intensity of the murmurs. One might expect to hear the murmurs best following the longer cycle lengths associated with her atrial fibrillation. I would wonder whether her heart rate remained so rapid as is described at the time that the reported auscultatory events were elicited.

I find I do not have enough information to explain what I see on the chest x-ray, namely, the very large heart. I would feel so much safer to know that there was an ejection murmur of aortic stenosis or something definite like that in the background. I would then be able to hang my hat on this and be more confident that I could make a diagnosis of underlying cardiac disease. So far, I have nothing specific.

Let's go on. The abdomen was distended with ascites. The liver was down 2 fingerbreadths. The spleen was not palpated. There was marked pitting edema of both lower extremities. Neurological examination showed fine tremor of the hands, marked hyperreflexia. Dr. Gwinup, how do you feel about reflexes in patients with hyperdynamic states? Do you just mark them down as hyperreflexic or do you note whether they are quick or slow?

DR. GWINUP: You try to note whether they are quick or slow. With hyperthyroidism they become exaggerated and hyperactive and they also quicken. It is easier to pick up clinically the slowness of a reflex in hypothyroidism than the shortening of the time of reflex in hyperthyroidism. It is very difficult for me to be certain that the reflex is shortened in time. As to why they change, I don't think there is any answer. It has nothing to do with nerve conduction and probably is due to changes within the muscle itself.

### Thyroid Storm?

DR. RUPPERT: I would like to ask the endocrinologist here whether this patient could be in the situation called "thyroid storm."

DR. GWINUP: I would say that I don't know what "thyroid storm" is. As the course of hyperthyroidism becomes accentuated one might note an arbitrary point at which to say, "This is thyroid storm." Most authorities would say first of all that the body temperature should be increased, and 101° is that usually given. Some say the pulse should be above 150. It usually happens in a patient who has stopped eating, very likely has infection, and just goes into an accelerated phase of hyperthyroidism, a decompensated phase. Where you draw the line is terribly arbitrary.

DR. WEISSLER: Dr. Wieland, what about the hyperpyrexia? This patient didn't have more than 101°.

DR. WIELAND: I agree entirely with Dr. Gwinup, and I do think that infection is an important

consideration. This temperature would fit in with fairly uncontrolled thyrotoxicosis but not storm.

DR. WEISSLER: Let us turn to the laboratory data. The hemoglobin was 8.8 Gm. She had a low hemoglobin which in itself could accentuate her circulatory reactivity. The white blood cell count was 8,766 with 88 polymorphonuclear leukocytes, 11 lymphocytes, and 1 monocyte. Certainly we don't have a brisk leukocytosis; we do have some shift to the left in the differential count. The urine was clear with a specific gravity of 1.005, no protein or sugar, no red cells, white cells or casts. The reticulocyte count was 1.4. Fasting blood sugar was 162. Of course she was fasting but was she getting intravenous glucose at this time? The serum sodium was 140, potassium 4.4, chlorides 110, blood urea nitrogen 17, guaiac negative, serology nonreactive, serum cholesterol 99. The cholesterol is distinctly low. The total bilirubin was 1.8. The total protein was 5.6 and the albumin/globulin ratio was 1/1. Serum iron was 24 mcg. with an iron-binding capacity of 366 mcg. Dr. Bouroncle, will you help us out here?

DR. BOURONCLE: The hemoglobin and hematocrit reflect a hypochromic anemia. With a low serum iron, and with the stool guaiacs, I imagine it was an iron deficiency anemia.

DR. WEISSLER: That's the kind of consultant I like — a direct answer — and she is reading ahead with regard to the stool guaiacs.

#### Anxiety and the BMR

The protein-bound iodine was 8.7 mcg., the basal metabolic rate plus 64. Do you think this patient had a *basal* metabolic rate? This patient probably wasn't basal from the moment she entered the hospital. What about the metabolic rate of 64, even in an active person? If you would actually measure oxygen consumption in people who are emotionally aroused, would you expect to come up with a metabolic rate of plus 64? I think Dr. Harris might help us here.

DR. HARRIS: Anxiety would elevate the BMR to only about 20 per cent, I would say.

DR. WEISSLER: That is a valuable point. People who are agitated do not usually have metabolic rates this high unless something is added to emotional factors producing hypermetabolism. Well, we repeated her stool guaiacs and now they were positive. The electrocardiogram on admission showed atrial fibrillation, and she had a rapid ventricular response. Now because she was so sick, a portable x-ray was taken and showed cardiomegaly, bilateral pleural effusion, and prominent vascular markings.

The impression on admission was thyrotoxicosis with thyrotoxic heart disease, cardiomegaly, atrial fibrillation, and congestive heart failure. She was functional Class IV; I will agree with that. Her

temperature on admission was 100.5° orally, and approximately two hours later it was up to 101.5°. The patient was started on intravenous sodium iodide and was given 0.4 mg. of Cedilanid®. She also received propylthiouracil, 500 mg. intramuscularly. What kind of dose is that, Dr. Gwinup? Is this very high??

DR. GWINUP: A great big dose.

DR. WEISSLER: Is that the kind of dose you give to someone who has severe hyperthyroidism?

DR. GWINUP: Very severe hyperthyroidism.

#### Raging Storm

DR. RUPPERT: May we ask whether she was now in storm — two hours later? We just put the temperature above the limit you mentioned.

DR. WEISSLER: I would think that she had quite active hyperthyroidism. I don't think it matters what you call it, as Dr. Gwinup has pointed out. You have to treat vigorously in any case.

DR. SILVERMAN: I saw this patient just one night. I know it was the impression of the attending staff that she was in storm. This woman was sitting there shaking, sweating, and extremely hyperactive and agitated. As a matter of fact, they had to tie her to the bed because she was falling out of bed and jumping all over.

DR. WEISSLER: Sounds like storm. This patient had very active disease and hyperactive responsiveness. What you want to call this is not so important as deciding that this is a disease that has progressed to the point that it requires rapid control.

The patient was placed in an oxygen tent, and at the end of four hours she had received a total of 1.2 mg. of Cedilanid, and at five hours she was removed from the oxygen tent and given oxygen by nasal cannula. She showed definite improvement in the respiratory distress. Twenty-four hours after admission the pulse rate was 120 and irregular. Her respirations were 22 and her blood pressure was now 130/70. The temperature was down to 98.6°. She was continued on propylthiouracil, Lugol's solution 5 drops every six hours, penicillin, etc. You see the medication listed in the protocol. Dr. Gwinup, do you think that the therapy she received in that 24-hour period was sufficient to account for the improvement in symptoms on the basis of thyroid disease alone?

DR. GWINUP: That's hard to answer. I should say that she was my patient and my opinion may be prejudiced. I would say that her response was largely due to therapy and was better than we could hope for in the average patient. If you take a patient with raging thyrotoxicosis — and that might be a better term than storm — and just put them in the hospital and sedate them, they sometimes improve very quickly. I think it was a combination of rest, putting



her in oxygen, cutting down on the work of breathing, and giving her all the medications. Her response was certainly very favorable.

DR. SCARPELLI: Do patients with real thyrotoxic heart disease respond with digitalis as well as she apparently did?

DR. GWINUP: I would say no, it is quite ineffective and other measures are much more important than digitalis.

DR. WEISSLER: During the second 24 hours the patient was given 0.5 mg. digoxin, and at this time the pulse rate ranged between 110 and 130. During the first week of hospitalization she was continued as above, and repeat stool guaiacs were positive. It was decided not to x-ray her, and she was started on antacid therapy. The patient had no weight loss during the first five hospital days. On the sixth day she was started on Aldactone-A® and Diuril®, and by the tenth day she had lost 14 pounds with marked improvement in her edema. On the eighth day Solu-Cortef® was discontinued, and treatment with prednisone was begun, which was later decreased to 3 mg. twice a day. So she now seemingly was getting quite a bit better. Dr. Ruppert, as a gastroenterologist, do you think antacid therapy helps the course of bleeding if it was due to an ulcer?

#### Gastrointestinal Bleeding

DR. RUPPERT: I think what you are doing is neutralizing acid, which hopefully will prevent progression of the ulcer or the continuation of the ulcer, but I think it is of interest to note that some investigators have reported that it is very rare to find peptic ulcer disease in thyrotoxicosis, the reason being that they shunt blood flow away from the mucosa of the gastrointestinal tract so that less hydrochloric acid is produced. Other people say this is the reason that they develop ischemic necrosis and bleeding. To bring it up in this case, we have severe congestion and you would wonder whether the bleeding wasn't on the basis of severe congestion of the gastrointestinal tract.

DR. WOOLEY: The patient was receiving drugs, like reserpine and corticosteroids, which would add to the problems the clinicians faced in a patient with positive stool guaiacs.

DR. WEISSLER: It's going to be an important question since gastrointestinal examination could not be obtained. We will have to find out about this from Dr. Scarpelli. Cardiac congestion in general doesn't cause bleeding unless there is something else in the picture. We do see generalized bleeding from the gastrointestinal tract in patients with terminal disease. Critically ill patients, young or old, for some reason react in their gastrointestinal tracts by oozing blood all along the gastrointestinal tract. This might well be an explanation for her problem.

At the end of two weeks the patient had lost 31 pounds. Was this mostly edema fluid?

RESIDENT: Yes.

DR. WEISSLER: That's rather severe diuresis, and this of course is important in view of the fact that she didn't make it through the hospitalization. Had she been receiving any potassium therapy throughout this diuresis?

DR. RUPPERT: No.

DR. WEISSLER: Chest x-ray demonstrated improvement in the congested lung. Treatment of the patient with reserpine, propylthiouracil, Diuril, Aldactone, digoxin, Lugol's solution, and Amphojel®. Grant, what do you think about this diuresis and its relation to potassium loss?

#### Potassium Deficit

DR. GWINUP: She was given Aldactone along with the thiazide, which of course would minimize her potassium loss.

DR. RUPPERT: Steroids were continued and potassium was not given orally because of the gastrointestinal tract findings. This is stated in the Progress Notes.

DR. WEISSLER: Of course, when the house staff looked at the electrolytes they might justify withholding potassium. The  $\text{CO}_2$  was 30, the sodium 135, potassium 4.9, and chlorides 104. I think we should make the point that a low body potassium isn't always reflected in a low serum potassium, and one could have severe potassium depletion with relatively normal serum levels of potassium. We often look at the other electrolytes to tell when there is potassium depletion. The presence of hypochloremic alkalosis is probably a more significant indication of a low body potassium than is the serum potassium level alone. When we look at the levels in our patient we find that there is no hypochloremic alkalosis of note; the chlorides were 104, the  $\text{CO}_2$  30.

The electrocardiogram showed atrial fibrillation and digitalis effect. On the sixteenth hospital day the pulse was 150. Digitalis intoxication was considered, but the patient had no other manifestations of intoxication. What does that mean? Could you have electrocardiographic evidence of digitalis intoxication without having any of the gastrointestinal or visual signs of digitalis toxicity? The answer is of course, yes. There was persistent dullness in the right base and occasional râles. Twenty-four hours prior to death, on the twentieth day, the patient developed severe nausea and vomiting and her pulse was 150. Now was the heart rate of 150 with atrial fibrillation?

RESIDENT: With atrial fibrillation.

DR. WEISSLER: The house staff was evidently thinking of the unusual case where the ventricular rate in

atrial fibrillation actually accelerates with digitalis intoxication.<sup>2</sup> The chest was clear with no râles. The blood pressure at this time was 144/84, and the digitalis at this time was discontinued. The serum sodium was 141, potassium 4.5, chlorides 106, hemoglobin 9.3, hematocrit 33, and the reticulocyte count was up to 8.5. She might have been continuing to lose blood at this time. Is that right, Dr. Bouroncle?

DR. BOURONCLE: Not necessarily. They were treating her with Imferon®, so it might be a regenerating blood picture.

DR. WESSLER: Thank you. Approximately four hours later the electrocardiogram showed complete heart block with a ventricular response of 75. This is most unusual. Why should this woman suddenly develop complete heart block at this time?

RESIDENT: Was this a manifestation of her digitalis intoxication?

### Underlying Heart Disease?

DR. WESSLER: This really looms forth as a distinct possibility. When any patient enters the hospital with thyrotoxicosis and heart failure, one of the first things to think of is underlying heart disease, and in particular, the younger the patient the more likely is the possibility. The patient was 42, she came in with severe congestive heart failure, and now she develops heart block. I think we could jump to digitalis as the first possibility, but in this interim period when she was feeling better, did we derive any clues as to the presence of heart disease in the background? I think there was interest in this point when the question was asked about the heart murmurs when her heart rate slowed.

DR. SCHIEVE: Would you clarify your statement that the younger the patients the more likely they are to have underlying heart disease?

DR. WESSLER: If a young patient, this is, the individual below 40 years, with hyperthyroidism develops congestive heart failure, there is a good possibility that the patient has heart disease since the young cardiovascular system can normally tolerate this disease without failing. Usually it is rheumatic heart disease. This is a good general rule. By and large in all age groups the development of heart failure or atrial fibrillation in patients with thyrotoxicosis is associated with a high incidence of underlying heart disease. The incidence of organic heart disease is particularly common in the younger age group under these circumstances. In the age group above 40, congestive failure and atrial fibrillation more commonly appear in hyperthyroidism in patients in whom no apparent cardiac disease is uncovered after the hyperthyroid state is controlled.<sup>3,4</sup>

DR. SCHIEVE: What you are really saying is that

heart disease in young people is easier to detect with the stethoscope than heart disease in older people.

DR. WESSLER: I would say so. People 40 and older may have sufficient atherosclerotic disease to impair the cardiac response in the presence of a high metabolic demand and they may develop congestive failure. But this is a presumption that has not really been proven.

### Heart Block

DR. WOOLEY: This heart block business is very disturbing from several points of view. One is that she has always had a fast ventricular response, and you wonder if perhaps she had a myocardial problem from the very beginning, with endocardial injury, subendocardial hemorrhage, etc. Second, metabolic problems have been profound over a period of several weeks now. The fact that she got so much better but continued this fast ventricular response remains disturbing. You have metabolic problems and you have the problem of somebody getting reserpine and digitalis, which may antagonize each other. Certainly with massive diuresis in somebody getting digitalis you have the setup for digitalis intoxication.

DR. WESSLER: I think these points are very well taken, Dr. Wooley. Let's follow what happens. An intravenous infusion of 60 mEq. of potassium with 500 cc. of dextrose in water was started. The patient had no improvement in her heart rate. I wouldn't have expected it then, because one doesn't attain improvement with potassium therapy in advanced atrioventricular block due to digitalis intoxication. Potassium actually accentuates the block in digitalis-induced A-V block of high degree as shown by Fisch and associates.<sup>5,6</sup> With this infusion over an eight-hour period, the electrocardiogram showed widening of the QRS complex. Dr. Wooley mentioned the combination of reserpine and digitalis. Lown and associates<sup>7</sup> have demonstrated that reserpine may sensitize patients to digitalis intoxication. Hypokalemia sensitizes patients to digitalis intoxication as well. However, when the digitalis intoxication is expressed as a high degree atrioventricular conduction block, the administration of potassium may actually accentuate the conduction disturbance.

DR. HARRIS: May I ask you to comment on the ventricular rate of 75?

DR. WESSLER: In an individual with complete heart block the heart rate is usually 50 or less. When the heart rate is fast in complete heart block one suspects that something else is pushing the ventricular pacemaker to initiate a beat at a more rapid rate; either an idioventricular rhythm is being stimulated by catechols, or thyroid hormone, or the diagnosis is incorrect and there is some concealed conduction from the atrium.

QUESTION: At this point, do you think she is still thyrotoxic?



DR. WEISSLER: I think that the pacemaker is influenced by high thyroid activity. I can't find any other explanation. She has been reserpinized, which slows the heart rate in complete heart block. She doesn't have circulating catechols of great amount; they've been depleted by the reserpine. So I would have to give some other reason than catechol excesses to explain the rapid ventricular rate with complete heart block.

DR. WOOLEY: What about this possibility: She has atrial fibrillation with the block and perhaps this is a nodal rhythm with an aberrant conduction system?

DR. WEISSLER: It could be. Let's look at the electrocardiograms. We've seen patients with atrial fibrillation and complete heart block. These individuals show regular ventricular rhythm at the usual slow rate of complete heart block.

DR. RUPPERT: This EKG was taken I think within one day of the time of admission.

DR. SCHOENFELD: I can't see much but the atrial fibrillation at this time.

DR. RUPPERT: This one was taken at approximately the middle of her hospital course.

DR. SCHOENFELD: Her ventricular response has gotten a little faster.

DR. RUPPERT: The next electrocardiogram was taken at the time she developed the slow ventricular response, just prior to the potassium infusion, I believe.

DR. WEISSLER: The QRS *has* changed in its configuration. Dr. Schoenfeld, what do you think?

DR. SCHOENFELD: Yes, they have changed. It looks like a right bundle branch block, which suggests a focus in the left ventricle.

DR. RUPPERT: Do those look regular enough? Would you think more about a nodal than idioventricular pacemaker?

DR. WEISSLER: I think the point is that she has lost her pacemaker activity from the atrium. That is, her fibrillating atrium is not stimulating her ventricle through the A-V node. Whether or not her pacemaker is an idioventricular focus deep down in the conduction system, or whether it is merely at the node cannot be decided. The fast heart rate suggests more that the pacemaker is in the nodal area rather than low down. The marked QRS aberration, however, suggests that it is lower down. She could have a nodal pacemaker and aberrant ventricular conduction. Thyroid activity also must be considered as a factor in the rate of the pacemaker. We cannot definitely explain the nature of the A-V block.

DR. WEISSLER: Let us continue with the protocol. Her blood pressure fell to 100/50 with a pulse rate of 72 and respirations of 24. That is a rather

severe change. When the heart rate actually slowed, her blood pressure dropped. This again raises the issue of myocardial disease. With a rate of 75 now, I would expect that if she didn't have any underlying heart disease her circulation would be adequate. What I mean to say is that this patient's heart rate has slowed to a regular rhythm in the range of 70. Even though she had an underlying conduction disturbance producing this slow heart rate, the myocardium should be responding sufficiently to keep her out of failure. Since we were so far along in the thyroid treatment I wouldn't expect that the hyperthyroidism was making such a demand on the heart that a rate of 72 couldn't keep up with it, that is, unless there is something else in the myocardium underlying this change.

QUESTION: What if she is still thyrotoxic, though?

DR. GWINUP: I would say that she should be euthyroid by this time.

DR. WEISSLER: I think this is the important point. The patient is left with something that is continuing to keep her in heart failure and allowing her to collapse even though she had a normal ventricular rate. Attempts at external pacemaking and cardiac massage were unsuccessful, as was trans-thoracic pacemaking, and the patient died. Could we look at the x-rays?

DR. DUNBAR: I don't think I can answer the major question of whether this is just thyrotoxicosis or whether coronary heart disease is superimposed. The admission portable film shows obvious cardiac enlargement, decompensation, pulmonary edema, and bilateral pleural fluid plus the bulging flanks of the ascitic abdomen. The films some 18 days later show considerable improvement. The heart remains generally enlarged, with a rather nonspecific configuration. Right pleural fluid remains, and in the presence of residual ascites I can't say whether there is hepatosplenomegaly. So basically, we have a big failing heart that moderately improved over 18 days of treatment. I don't see specific evidence of mitral heart disease. In a young individual with aortic stenosis of course we look for left ventricular hypertrophy and localized poststenotic dilatation of the ascending aorta. As people get older and the aorta increases in size with arteriosclerosis or hypertension, the aorta gets generally big and these findings are no longer so valuable. I don't think that there is primary valvular heart disease in this patient.

DR. WEISSLER: We are now getting into the area where we do not have sufficient information from the protocol to make a specific etiologic decision and we are going to have to speculate on the basis of the data that we have. One thing that would help some was the state of her thyrotoxic myopathy. Did she have much skeletal muscle weakness?

RESIDENT: Yes, she did.

DR. WEISSLER: Did this persist throughout the 20-day period?

RESIDENT: She was considerably improved from this standpoint, but she was still very weak. Actually, about four days prior to her death she was beginning to ambulate a little bit.

DR. WEISSLER: Let us summarize. I guess there is an inclination to attribute her death to excessive digitalis therapy. Somehow I am not inclined to make this diagnosis, mainly since I do not think that Dr. Scarpelli is going to show us anything that will settle the question of digitalis intoxication. I suspect that this was a factor promoting death, but I wonder whether or not we have something else beneath the whole picture. Could it be valvular disease? We have no good evidence for that. Left ventricular hypertrophy is not present to indicate underlying left ventricular disease, at least the electrocardiogram hasn't given us this. Diastolic hypertension did not persist. There is no clear evidence for coronary artery disease. The right bundle branch block did not develop until very late in the course, so I have no reason to think of chronic overstrain on the right side of the heart.

### Thyrotoxic Heart Disease Infrequent

I think I would like to call on the law of parsimony of diagnosis and say that all this was hyperthyroidism; that the hyperthyroidism, as it *frequently* does, affected the skeletal muscle and also, as it *infrequently* does, affected the myocardium. As I recall, thyrotoxicosis generally does not cause heart disease and does not cause any specific lesions in the heart. There have been studies in which thyrotoxic hearts were compared with non-thyrotoxic hearts, with sex and age matched. It has been the finding that the changes seen in thyrotoxicosis could not be distinguished from the findings in the euthyroid population.

Every once in a while there is the report of an infiltration of excessive degree in the myocardium in hyperthyroidism, appearing somewhat like the skeletal muscle disease of hyperthyroidism, in which there is more than the usual amount of round cell infiltration, some fraying of the myocardial fibers, and evidence of hypertrophy that can't be explained by other disease. I would wonder whether in this particular case we were dealing with an altered myocardium, even though it is most unusual to find this in thyroid disease, and I would wonder whether there will be direct evidence of change in the myofibrils. While we do not have electron microscopic sections, we would see this on routine pathologic section. I wouldn't expect marked fibrosis, but I might suspect that she would have some fibrosis in the myocardium. Dr. Wooley, what would you say?

DR. WOOLEY: I commented earlier on her continued fast pulse rate when otherwise she seemed to

be improving a great deal. This makes you think that there is a myocardial lesion here and that this is not the usual thyroid heart but is what clinicians have documented in malignant thyroid disease. It is not uncommon to see subendocardial hemorrhages, subendocardial lesions, in certain situations. In animals you could do this with norepinephrine infusion over a period of time; excessive catechols can induce this sort of injury. So I see no reason why you couldn't get a similar problem as Dr. Weissler has mentioned in the myocardium in this situation. We are left also with the problems the pathologist cannot answer, that is, how much of this could have been related to drug therapy, potassium depletion, and digitalis as well.

DR. WEISSLER: We should at least raise the possibility of multiple pulmonary emboli. Her pulmonary findings seemed to remain for a long time. Anyone who has had a serious bout of heart failure and atrial fibrillation may develop complicating multiple pulmonary emboli, and we shall at least look for these. In hyperthyroidism, phlebitis and emboli seem to be much less of a problem than in forms of heart failure with *low* cardiac output. We really have no good evidence for rheumatic heart disease. The diastolic pressure did come down, so I don't think she had underlying hypertension. I am afraid that we can't come up with anything more specific than myocardial disease which is related to excessive thyrotoxicosis; that such changes may be found throughout the body, the heart being involved only as part and parcel of the overall process.

### CLINICAL DIAGNOSIS

1. Hyperthyroidism.
2. Thyrotoxic heart disease.

### PATHOLOGIC DIAGNOSIS

1. Thyrotoxic heart disease with interstitial and myocardial fibrosis.
2. Organizing thrombus, right auricular appendage of heart.
3. Nodular hyperplasia and follicular adenoma of thyroid.
4. Severe fatty infiltration of peripheral striated voluntary muscle.

### DISCUSSION OF PATHOLOGY

DR. SCARPELLI: The body was fairly well nourished and showed bilateral exophthalmos. The heart weighed 350 Gm. and showed marked dilatation of the left ventricle. The myocardium was pale gray and soft. The right atrial chamber and auricular appendage contained an organized thrombus. The valves and coronary arteries showed no abnormalities. The lungs weighed 190 and 160 Gm. and contained surprisingly little fluid. The stomach and small intestine were lined by an intensely hyperemic mucosa; however, a careful search failed to reveal areas of



ulceration. The thyroid gland weighed 45 Gm., was greenish-gray and had a nodular surface. On cut surface the nodules were gelatinous in consistency, and were diffusely distributed throughout the gland. In the left lateral lobe of the thyroid there was a well-circumscribed 4 mm. whitish-gray, soft nodule. Four parathyroids were recovered; these were of normal size and appearance. The sartorius muscle was gray and appeared fatty.

*Microscopic examination* of the myocardium showed extensive fibrosis with focal areas of muscular hypertrophy. Some of the myocardial muscle cells were surrounded by inflammatory cells in the interstitium; these were predominantly lymphocytes. The septum showed essentially the same pathologic change. The thyroid gland showed the classical changes consistent with hyperthyroidism, such as small follicles lined by cuboidal epithelium and containing scant amounts of colloid. Many of the follicles were collapsed, showing no lumen, and were lined by pale-staining Hürthle cells indicative of epithelial cell injury. Some of these changes were no doubt the result of massive propylthiouracil therapy. There was a single focus which showed a follicular adenoma. The peripheral striated muscle showed marked variation of muscle cell size, focal proliferation of sarcolemmal nuclei, and extensive replacement of muscle by fat.

The pathologic alterations encountered in the patient are those of hyperthyroidism with secondary

myocardial injury. Death was probably the result of interference with normal conduction. Although this degree of myocardial damage is not usually seen in thyrotoxicosis,<sup>8</sup> it must be remembered that this woman had had this problem for about 25 years. The peripheral myopathy she showed is identical to that first described in hyperthyroidism by Askanazy in 1898.<sup>9</sup> The mechanism by which excess thyroid hormone exerts its pathologic effect may be due to interference with normal production and conservation of energy by cell metabolism.<sup>10</sup> This is especially true in heart muscle where energy demands are high and continuous throughout life. Dr. Weissler and his colleagues are to be congratulated on a cogent and stimulating discussion of this case.

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**CHILDHOOD THYROTOXICOSIS** appears to have a higher incidence in the United States than elsewhere. A genetic influence was suggested by the frequency of disorders in close relatives of the patients. The onset of thyrotoxicosis was often related to physical or psychological stress.

The clinical manifestations were easily recognizable and diagnosis required few laboratory aids. In view of the lack of proper understanding of the etiology, cure has not been achieved. Good control was, however, obtained with surgical treatment. Though certain underlying genetic and psychosomatic characteristics tended to persist after treatment, the physical, emotional, and mental development of these children was not affected. Hypothyroidism and tetany were serious complications of surgical treatment, and the frequency of their occurrence indicated the need for better therapeutic measures.

Medical treatment of juvenile thyrotoxicosis emerges as even less satisfactory. The incidence of failure, recurrence, and toxicity is so high that ultimately recourse to surgery is necessary in one-fourth of the patients. The inadequacy of the methods at present available necessitates urgent search for better therapeutic measures. Radioiodine treatment has proved to be eminently suitable for adults. The question whether this might prove useful in children also is still unanswered. Our experience with this method, though not extensive, appears hopeful enough to justify its further exploration under careful qualified medical supervision, with special emphasis on long-term follow-up. — Krishna M. Saxena, M.D., John D. Crawford, M.D., and Nathan B. Talbot, M.D., Boston, Mass.: *British Medical Journal*, 2:1153-1158, November 7, 1964.

## LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

# LOMOTIL<sup>®</sup>

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride .....2.5 mg.

(Warning: May be habit forming)

atropine sulfate .....0.025 mg.

tablets • liquid



**slows propulsion**



**relieves distress**



**stops diarrhea**



*Precautions:* Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

*Dosage:* For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses*, until diarrhea is controlled, are:

**Children:**

- 3 to 6 months—3 mg. ( $\frac{1}{2}$  tsp.\* t.i.d.)
- 6 to 12 months—4 mg. ( $\frac{1}{2}$  tsp. q.i.d.)
- 1 to 2 years—5 mg. ( $\frac{1}{2}$  tsp. 5 times daily)
- 2 to 5 years—6 mg. (1 tsp. t.i.d.)
- 5 to 8 years—8 mg. (1 tsp. q.i.d.)
- 8 to 12 years—10 mg. (1 tsp. 5 times daily)

**Adults:**

- 20 mg. (2 tsp. 5 times daily or
- 2 tablets 4 times daily)

*\*Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**SEARLE**

*Research in the  
Service of Medicine*

# Presenting the Officers of OSMA For the Current Year

THE House of Delegates of the Ohio State Medical Association named a President-Elect and one new Councilor at the 1965 Annual Meeting held May 9 through 14 in Columbus, where the Incoming President was installed and several members of The Council re-elected. Following are biographical sketches of the new officers with additional information on other members of The Council.

Dr. Lawrence C. Meredith, of Oberlin and Elyria, was named President-Elect of the Association after serving five years on The Council as Councilor of the Eleventh District. He will be installed as President at the 1966 Annual Meeting to be held in Cleveland the week of May 22. Dr. Meredith is a practicing physician with offices in Elyria where he limits his field to otolaryngology.

His home is in Oberlin. Although a native of Syracuse, N. Y., Dr. Meredith has lived much of his life in the Lorain County area where his late father, Dr. Lawrence C. Meredith, Sr., practiced, before him, specializing in the field of eye, ear, nose and throat work.



Lawrence C. Meredith, M. D.

Long active in medical organization work, Dr. Meredith is a former secretary-treasurer of the Lorain County Medical Society and for many years was editor of the Society's news letter. He was first elected to The Council, as Councilor of the Eleventh District, in 1960 and was twice re-elected to that office, being in the midst of his third term when named to the higher office.

Since becoming a member of The Council, he has served on a number of important committees. Last year he was chairman of the Association's Auditing and Appropriations Committee.

Dr. Meredith took his undergraduate work at Oberlin College and at Ohio State University. The medical degree was received from Ohio State University College of Medicine in 1945, and internship followed at University Hospitals in Columbus. Fraternal

affiliation is Alpha Kappa Kappa.

During World War II, Dr. Meredith served in the Army Medical Corps and attained the rank of captain. Among assignments, he was post surgeon in Panama.

Residency training in otolaryngology was at University Hospitals in Cleveland. Since 1950 he has limited his practice to the ear, nose and throat specialty and in 1953 was made a Diplomate of the American Board of Otorhinolaryngology. In addition to his hospital appointments, he has served as secretary-treasurer, vice-president and president of the staff at Elyria Memorial Hospital.

In addition to his memberships in the local Medical Society and the State organization, he is a member of the American Medical Association, a Fellow of the American Academy of Ophthalmology and Otolaryngology, a member of the Ohio Committee on Trauma, member of the Cleveland Otolaryngological Club, the Cleveland Medical Library Association and the Elyria Chamber of Commerce; also the Congregational Church in Oberlin.

Dr. and Mrs. Meredith are the parents of three children: A son in Ohio State University, a daughter in Junior High School and a second son in elementary school.

The Council of the Ohio State Medical Association consists of the President, the President-



Elect, the Immediate Past-President, the Treasurer, and one Councilor from each of the 11 Councilor Districts. Following is additional information on members of The Council:

#### Incoming President

Dr. Henry A. Crawford, Cleveland, assumed the office of President at the close of the 1965 Annual Meeting, and will serve in that office until the 1966 Annual Meeting to be held in Cleveland the week of May 22. He was named president-elect at the 1964 Annual Meeting after serving four years as Councilor of the Fifth District.



H. A. Crawford, M.D.

During the past year, as President-Elect, Dr. Crawford travelled extensively and worked diligently in behalf of the Association. He has attended numerous national meetings and conferences as an official of OSMA, and in Ohio has been continuously on the go to meet with statewide planning groups, district conferences and county meetings.

His speaking engagements have been numerous. As ex-officio member of the Association's numerous committees, he has been in Columbus many times to meet with committee members.

Dr. Crawford is a practicing general surgeon and proctologist in the Cleveland area. In addition to his medical organization activities, he has distinguished himself in military service, attaining the rank of full colonel in the Air Force.

A native of Nelsonville, Dr. Crawford received his bachelor's degree from Ohio Wesleyan University and his medical degree from Western Reserve University School of Medicine in 1927. Following internship and residency training at University Hospitals in Cleveland, he entered practice in 1932. He has been certified by the American Board of Surgery and is a Fellow of the American Protological Society.

Dr. Crawford is a Past-President of the Academy of Medicine of Cleveland and Cuyahoga County and has been a member of the Academy's Board of Directors. He has served as member and chairman of numerous local committees, among them, the Joint Academy-Hospital Council Committee, the Joint Medical Legal Committee, the Committee on Public Policy and Legislation, the Committee on Constitution and Bylaws, Committee on Planning and Building, and many others.

In 1961, Dr. Crawford completed 37 years of military service with the Air Force and the National Guard. From 1940 to 1946, he was on active duty and was assigned during much of the war period to the China-Burma-India Theater. In 1948 he was made Surgeon of the 121st Fighter Interceptor Wing

of the Air National Guard and was awarded the Air Medal and the Bronze Star.

Military affiliations include also membership in the Aero Space Medical Association, membership in the National Guard Association of Ohio, of which he is a past-president, and membership on the Military Medical Affairs Committee, Council on National Defense of the American Medical Association.

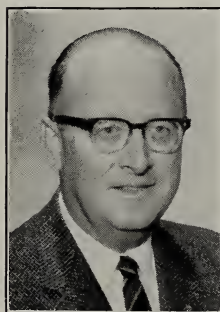
Dr. and Mrs. Crawford make their home in the Shaker Heights area. Mrs. Crawford is active in civic and church affairs as well as in the Woman's Auxiliary.

#### Eleventh District Councilor

The House of Delegates elected Dr. William R. Schultz, of Wooster, as Councilor of the Eleventh District to fill one year of the unexpired term of Dr. Lawrence C. Meredith who was named President-Elect.

A practicing physician in Wooster since 1946, Dr. Schultz limits his field to otolaryngology. He has been certified as a Diplomate of the American Board of Otolaryngology.

Other professional associations in his specialty field include Fellowship in the American Academy of Ophthalmology and Otolaryngology, membership in the Cleveland Otolaryngological Club, the Akron Academy of Ophthalmology and Otolaryngology and the Ohio Valley Allergy Society.



Wm. R. Schultz, M.D.

Dr. Schultz has shown an outstanding interest in work and improvement of hospitals. He is a former chief of staff of the Wooster Community Hospital; also a member of the Board of Governors of the same hospital and chairman of its Building Committee. Another affiliation is that as a member of the Health Appraisal Committee of the Cleveland Regional Hospital Planning Board.

On the State level, Dr. Schultz is at present chairman of the OSMA Committee on Hospital Relations. At the Institute of Emergency Room Planning and Staffing held in Columbus in 1964, he spoke on the topic, "Medical Aspects of Emergency Room Planning." Again at the County Medical Society Officers Conference held in 1965, he spoke on the topic, "Areawide Health Facilities Planning."

In other medical organization activities, he has served as president of the Wayne County Medical Society; also for several years as a Delegate of that Society to OSMA.

Dr. Schultz graduated from the College of Wooster and received his medical degree from George Washington Medical School in 1939. Internship followed at the University of Pittsburgh. Residency work in his specialty field was taken at Washington

University and Barnes Hospital in St. Louis. From 1943 to 1946 he served with the Army Medical Corps where he attained the rank of major, being assigned to the 70th General Hospital.

Dr. Schultz is a member of the AMA; past-president of the Wayne County Mental Health Association and crusade chairman for the Wayne County Cancer Society. Other offices held include that as president of the Wooster Board of Education, president of the Wooster Rotary Club and member of the Board of Directors of the local YMCA and the Chamber of Commerce.

He is a member of the Corporation of Boy's Village, Smithville, a director of the Citizens National Bank of Wooster and director of the Wooster Auto Club; also an Elder in the Presbyterian Church, a member of the American Forestry Association, the Isaac Walton League, the Century Club, the Wooster Country Club and the Elks Lodge.

Dr. and Mrs. Schultz have three children: William R. Schultz, Jr., now in the Graduate School of Social Science at Ohio State University; Margaret, a Junior at Wittenberg University; and Harvey, a junior at Wooster High School.

#### Other Members of The Council

As Immediate Past-President, Dr. Robert E. Tschantz, Canton, will serve an additional year on The Council.

Dr. Theodore L. Light, Dayton, was re-elected Councilor of the Second District. He was first elected to that office in 1963.

Dr. Robert N. Smith, Toledo, was re-elected Councilor of the Fourth District. He was first elected to that office in 1963.

Dr. Edwin R. Westbrook, Warren, was re-elected Councilor of the Sixth District. He was first elected to that office in 1963.

Dr. Robert C. Beardsley, Zanesville, was re-elected Councilor of the Eighth District. He was first elected to that office in 1961 and was re-elected in 1963.

Dr. Robert L. Fulton, Columbus, was re-elected Councilor of the Tenth District. He was first elected to that office in 1963.

Councilors in the midst of two-year terms are: Dr. Robert E. Howard, Cincinnati, First District; Dr. Frederick T. Merchant, Marion, Third District; Dr. P. John Robeck, Cleveland, Fifth District; Dr. Benjamin C. Diefenbach, Martins Ferry, Seventh District; and Dr. George N. Spears, Ironton, Ninth District.

Dr. Philip B. Hardyman, Columbus, is serving a three-year term as Treasurer.

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A gift of \$750,000 from the George C. Gordon trust was given to the Cleveland Clinic Foundation. Another gift of \$800,000 was given to University Hospitals of Cleveland from the same trust.

## Report on Physicians Licensed To Practice During 1964

The 63rd annual report on medical licensure statistics appears in the June 7 *Journal of the American Medical Association*.

A total of 7,911 physicians were newly added to the licensed medical profession in the U. S. in 1964, according to the report by the AMA Council on Medical Education.

There were 6,605 newly licensed U. S. and Canadian medical school graduates and 1,306 graduates of medical faculties in other countries. Newly licensed foreign medical graduates have gradually decreased each year since the high of 1,626 in 1959. In recent years, about one quarter of foreign-trained graduates issued first licenses have been U. S. citizens who attended medical schools outside the U. S. and Canada.

A total of 17,885 licenses to practice medicine and surgery were issued during 1964 by 55 authorized boards in the U. S. and its territories. This total included first licenses for new physicians, licenses for physicians moving to other states, and licenses for foreign-trained physicians.

Of all licenses issued during 1964, 7,166 were granted after successful written examination and 10,719 by reciprocity and endorsement of state licenses or the certificate of the National Board of Medical Examiners.

In Ohio, the report shows, 417 physicians were licensed by examination, and an additional 551 by reciprocity and endorsement, or a total of 968. Considering duplication of licensure in various states, it is estimated that the number in Ohio represents a total of 459 physicians added to the medical profession during the year.

Of physicians examined and licensed in the various states, the number of graduates of Ohio's three medical schools were as follows: University of Cincinnati College of Medicine, 83; Western Reserve University School of Medicine, 54; and Ohio State University College of Medicine, 151.

As of Dec. 31, 1964, there were 284,271 physicians in the U. S. (excluding 1,740 temporarily in other countries).

Licensing board examination failures in 1964 totaled 1,181. The percentage of failures in the written examinations of graduates of approved U. S. medical schools was 1.7; of graduates of approved Canadian medical schools, 7.8 per cent failed. Graduates of schools of osteopathy admitted to medical licensure examination in several states had 9.4 per cent failures, and 31.08 per cent of foreign-trained physicians examined for medical licensure failed. The total percentage of failures was 13.4 per cent, about the same as 1963.



# Proceedings of the House of Delegates 1965 Annual Meetings

## MINUTES OF FIRST SESSION

THE first session of the House of Delegates of the Ohio State Medical Association was held in the Mars and Jupiter Rooms of the Columbus Plaza Hotel, Columbus, Sunday evening, May 9. A dinner was held in the Saturn Room preceding the business session.

The Reverend George L. Murphy, Gesu Parish, Cleveland, offered the invocation.

Following the invocation, Dr. John R. Huston, Columbus, President of the Columbus Academy of Medicine, welcomed the delegates to Columbus and introduced President Robert E. Tschantz, Canton, who delivered his presidential address. (See page 656 for Dr. Tschantz's address.)

### Report on Delegates Present

The President then called for a roll call by the Executive Secretary who reported 154 delegates seated and eligible to vote. A number of alternate-delegates, officers and executive secretaries of county medical societies were in attendance.

### 1964 Minutes Approved

The minutes of the 1964 sessions of the House of Delegates, as published in the June, 1964, issue of *The Ohio State Medical Journal*, were approved by official action.

### Introduction of Honored Guests

Before proceeding with the business of the session, Dr. Tschantz introduced the following honored guests:

Dr. Richard A. Kern, Philadelphia, Pa., president of the Pennsylvania Medical Society; Dr. Albert C. Esposito, Huntington, West Virginia, president of the West Virginia State Medical Association; Dr. James S. Klumpp, Huntington, West Virginia, past-president of the West Virginia State Medical Association; Dr. Richard K. Mosbaugh, Cincinnati, president of the Ohio State Dental Association; Mr. James H. Moss, Cincinnati, president of the Ohio Hospital Association; Mr. Fred J. Cermak, Jr., Cleveland, president of the Ohio State Pharmaceutical Association; Dr. L. E. Green, Akron, president of the Ohio Veterinary Medical Association; Mrs. Margaret Swank, Newark, president of the Ohio State Society of Medical Assistants; Mrs. John D. Dickie, Toledo,

president of the Woman's Auxiliary to the Ohio State Medical Association; Mrs. Herbert F. Van Epps, Dover, president-elect of the Woman's Auxiliary to the Ohio State Medical Association; Mr. David Montgomery, Cincinnati, representative of the Student AMA Chapter, University of Cincinnati; Mr. Hugh McDonald, Columbus, president of the Student American Medical Association, Ohio State University.

### OSMA Past-Presidents Introduced

The following past-presidents of the Association also were introduced: Dr. Edwin H. Artman, Chillicothe; Dr. H. M. Clodfelter, Columbus; Dr. George J. Hamwi, Columbus; Dr. Charles L. Hudson, Cleveland; Dr. Robert S. Martin, Zanesville; Dr. Richard L. Meiling, Columbus; Dr. George W. Petznick, Cleveland; Dr. H. M. Platter, Columbus.

Also introduced were former members of The Council: Dr. R. Dean Dooley, Newark; Dr. John H. Mitchell, Columbus; Dr. Arthur J. Tronstein, Newark; Dr. Fred P. Berlin, Lima; Dr. Chester P. Swett, Lancaster.

Other guests introduced were: Mr. Harry Hinton, Chicago, field representative to the American Medical Association; Mr. George H. Saville, consultant to the Ohio State Medical Association; Mr. Charles S. Nelson, former executive secretary of the Ohio State Medical Association.

### Auxiliary President Presents Report

At this point Mrs. John D. Dickie, Toledo, president of the Woman's Auxiliary to the Ohio State Medical Association, was presented and gave a report on Auxiliary activities to the House of Delegates. (See page 669 for the text of Mrs. Dickie's address.)

### Reference Committees

The following committees were appointed by the President:

**Credentials of Delegates** — John A. Fraser, Columbiana County, Chairman; Carl W. Koehler, Hamilton County; C. J. Brian, Preble County; A. R. Callander, Delaware County; Sol Maggied, Madison County.

**President's Address** — Maurice F. Lieber, Stark County, Chairman; Robert M. Inglis, Franklin County; Jasper M. Hedges, Pickaway County; Charles H.

McMullen, Ashland County; Emil J. Meckstroth, Erie County.

**Resolutions Committee No. 1** — John H. Budd, Cuyahoga County, Chairman; John J. Cranley, Hamilton County; Maurice M. Kane, Darke County; Donald R. Brumley, Hancock County; V. William Wagner, Ottawa County; G. E. DeCicco, Mahoning County; R. E. Rinderknecht, Tuscarawas County; J. L. Kraker, Fairfield County; Harry Nenni, Lawrence County; Homer A. Anderson, Franklin County; A. B. Huff, Wayne County.

**Resolutions Committee No. 2** — J. Martin Byers, Highland County, Chairman; Kenneth D. Arn, Montgomery County; Dwight L. Becker, Allen County; William G. Henry, Lucas County; S. A. Burroughs, Ashtabula County; W. A. White, Jr., Stark County; Samuel L. Weir, Carroll County; O. D. Ball, Perry County; Keith R. Brandeberry, Gallia County; James C. McLarnan, Knox County; James T. Stephens, Lorain County.

**Resolutions Committee No. 3** — Frederick P. Osgood, Lucas County, Chairman; Carl A. Minning, Clermont County; Mason Jones, Montgomery County; Walter A. Daniel, Seneca County; L. J. McCormack, Cuyahoga County; Leonard V. Phillips, Summit County; Robert N. Lewis, Belmont County; K. E. Bennett, Washington County; William M. Singleton, Scioto County; Charles W. Pavey, Franklin County; Richard W. Avery, Medina County.

**Tellers and Judges of Election** — James G. Roberts, Summit County, Chairman; Clyde S. Roof, Hamilton County; R. C. Henderson, Greene County; James G. Tye, Montgomery County; William J. Neal, Fulton County; Edward F. Ockuly, Lucas County; William F. Boukalik, Cuyahoga County; Carl F. Goll, Jefferson County; Robert E. Swank, Ross County; A. J. Earney, Holmes County.

#### **Nominating Committee Elected**

The next order of business was the election of a Nominating Committee. The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

**First District** — Daniel V. Jones, Hamilton County.

**Second District** — James G. Tye, Montgomery County.

**Third District** — Fred P. Berlin, Allen County.

**Fourth District** — Edwin C. Winzeler, Henry County.

**Fifth District** — Paul A. Mielcarek, Cuyahoga County.

**Sixth District** — Edward A. Webb, Portage County.

**Seventh District** — Norman L. Wright, Coshocton County.

**Eighth District** — Joseph C. Greene, Muskingum County.

**Ninth District** — L. W. Starr, Hocking County.

**Tenth District** — Robert E. Swank, Ross County.

**Eleventh District** — William R. Graham, Huron County.

Dr. Tschantz then announced that under a system of rotation approved by the House of Delegates in 1963, chairman of the committee for this year would be the nominee from the Third District, Dr. Berlin.

#### **Presentation of Resolutions**

Dr. Tschantz then called for the presentation of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting should be read by title only for referral. Seventeen resolutions were read by title only and referred to the resolutions committees. (See minutes of the second session of the House of Delegates for text of each resolution and actions taken by the House at the second session.)

#### **Resolution Withdrawn**

Resolution No. 9, entitled "Eldercare Act of 1965," was withdrawn at the request of the sponsors.

#### **New Resolutions Presented**

Dr. Tschantz then called for the presentation of new resolutions. He ruled that any delegate wishing to present a resolution not submitted 60 days before the meeting should explain the purpose of the resolution and why it could not have been submitted in advance. He announced that such resolutions then could be received upon consent of two-thirds of the delegates present. The following resolutions were then submitted. All were accepted by the House of Delegates and all were referred to Resolutions Committee No. 3.

**Resolution No. 19**, "Maintaining Professional Freedom," submitted by Dr. Robert N. Smith, Lucas County, Councilor of the Fourth District.

**Resolution No. 20**, "Mental Health Planning," presented by Dr. Edmond K. Yantes, Clinton County.

**Resolution No. 21**, "Reorganization of Department of Mental Hygiene," presented by Dr. William G. Henry, Lucas County.

**Resolution No. 22**, "Preserving the Quality of Medical Care," presented by Dr. G. E. DeCicco, Mahoning County.

**Resolution No. 23**, "Change in AMA Health Education Leaflet," presented by Dr. Charles E. Jaeckle, Defiance County.

**Resolution No. 24**, "To define Justifiable Abortion," presented by Dr. Eduard Eichner, Cuyahoga County.

**Resolution No. 25**, "AAPS Essay Contest," presented by Dr. Charles W. Pavey, Franklin County.

#### **Awards to Medical Schools**

At this time the following distinguished guests were introduced and Dr. Tschantz presented to them American Medical Association Education and Research Foundation checks, representing money con-



tributed from Ohio for Ohio's medical schools during 1964; Dr. Richard L. Meiling, Columbus, representing the Ohio State University College of Medicine; Dr. Joseph Lindner, Jr., Cincinnati, representing the University of Cincinnati College of Medicine; Dr. John L. Caughey, Jr., Cleveland, representing the Western Reserve University School of Medicine.

### George H. Saville Honored

Mr. George H. Saville, consultant to the Ohio State Medical Association, was called to the rostrum. Dr. Tschantz presented to him a watch engraved as follows: "Scottie" — 30 years — O. S. M. A." and a plaque which contained the following message: "Presented by the Ohio State Medical Association to George H. Saville in recognition of his services to the people of Ohio and to the medical profession while serving The Association as Assistant Executive Secretary, 1935-1963 and Executive Secretary, 1964."

Following announcements about meetings of the reference committees and the second session of the House of Delegates, the House recessed until Tuesday evening, May 11.

### MINUTES OF SECOND SESSION

The second session of the House of Delegates of the Ohio State Medical Association at the 1965 Annual Meeting was held on Tuesday evening, May 11, in the Mars and Jupiter Rooms of the Columbus Plaza Hotel. A dinner in the Saturn Room preceded the session.

Following dinner, the meeting was called to order by the President. A roll call by the Executive Secretary showed 157 delegates seated and eligible to vote. Also present were alternate-delegates, officers and other guests.

Dr. Tschantz introduced Dr. Joe M. Black, Seymour, Indiana, president of the Indiana State Medical Association; and Dr. Luther R. Leader, Birmingham, Michigan, president-elect of the Michigan State Medical Society.

### Committee on President's Address

Following the introduction of honored guests, President Tschantz called for a report of the Reference Committee on the President's Address, which was presented by Dr. Maurice F. Lieber, Canton, delegate from Stark County and chairman of the committee. It read as follows:

"Your Reference Committee on the President's Address for 1965 considers Dr. Robert E. Tschantz's presentation delivered to this House of Delegates on May 9, 1965, to be one of the most outstanding speeches given before this 130 year old Association, and we say this fully mindful that the superlative has been traditional with countless Presidents of the OSMA of the past.

"The painstaking care that very obviously went into the preparation of his remarks typified to us that here indeed is reflected the 'M. D.' that we all treasure

and revere so much after our respective names . . . however, in this instance, the 'M' stands for modesty, and the 'D' for dedication.

"Without ever referring to his own constant, willing labors and sacrifices for organized medicine in this State, Dr. Tschantz reported and gave great credit to many others who have endeavored with him to make this fateful year in medicine bear fruit. This is proper, for no one man can administer this great organization alone, but your committee feels it is unnecessary to repeat each tribute and acknowledgement. However, we would be remiss if we did not note again the thanks of the Organization to Scottie Saville, to the current administrative staff, and if we did not here endorse Dr. Tschantz's sincere recommendation of our own Dr. Charles L. Hudson as a candidate for President of the AMA in June, 1965. It is important that we constantly remember why Dr. Hudson drew such a solid round of applause at the special session of the AMA in February, and that we re-affirm now and always for Dr. Hudson the fact that we agree with him, as Dr. Tschantz said, in Dr. Hudson's platform, so to speak, that:

"No person should be denied health care because of inability to pay.

"Government revenues should be used for such care only after other sources are proved inadequate.

"Every level of government should assume a financial responsibility.

"The standard of health care must be maintained.

"Voluntary pre-payment mechanisms should be used.

"Eligibility should be fair, realistic, practical, and uncomplicated.

"Funds only, and not direct services, should be provided.

"The money used should come from the general fund and not from Social Security taxes.

"Dr. Tschantz gave proper recognition to the work being done by many committees of this State Organization. He cited many things OSMA has done for the individual members. And he made an earnest plea for the very modest increase of dues recommended by Council. When one considers that most of us are spending more for our hotel rooms each night than this \$15 increase represents, your committee unanimously endorsed and supported our President's request for this increase. In these days of spiraling costs, with full recognition of what we get for our money, with an honest admission that each of us spends more than this amount for a weekend of golf or fishing, we could only feel that to deny these needed funds would be akin to a slap in the face to our officers, our administrative staff, and our mission as a profession — and a State Organization. As he said, we have the lowest state dues in the country, and this, contrasted with our position of national leadership, pointed out by Dr. Tschantz,

is tantamount to being untenable. So much for the 'modesty' aspect of this superb report.

"As to the 'dedication' of our President, your committee felt that nothing would be as appropriate as to repeat verbatim here his words which truly deserve repetition, over and over again, until they become an integral part of each and every one of us, namely:

"The health of the American people is medicine's most important concern. Medicine's position has been sound and morally right. It is with deep regret that I see the country so dear to my heart embarking on a course that historically, when it has been tried, always has led to a deterioration in the medical care of the patient. I have a deep and abiding faith in the American doctor to give his very best in the care of his patient. The fact still remains that a physician harassed by unnecessary bureaucracy, regulations and forms on the one hand, and unnecessary minor complaints from free-loading malingerers on the other, will be unable to give the best of himself to the truly ill. And then our President quoted Carl Schurz, who said 'Anything that is morally wrong, cannot be right in practice.' He then continued, 'To paraphrase, I say to you: Any proposed legislation that is morally, medically, and economically wrong cannot be right when it becomes law.' Truly, greater dedication than this 'hath no man.'

"The various changes in the format of this meeting brought about by our President were noted by your committee and approved. Efficiency was increased by eating in one room and recognizing our honored visitors there, and then moving to a fresh adjoining room for the business matters. This was deemed an improvement. However, following a suggestion from Summit County, our committee felt that an additional improvement can and should be made, within the framework of our Constitution, concerning the time-consuming roll call of delegates. And within the functions of this reference committee, we respectfully suggest that the President-Elect either appoint an ad hoc committee to study the feasibility of other methods or that Council discuss the matter. Our suggestion would be that the Councilors report for their districts.

"I said when I nominated this beloved friend of mine for the highest office in our organization: 'Here is a man who thinks like a President, who acts like a President, — why he even looks like a President.' My good friends, I put it to you now: Was I wrong, or was I right?

"Bob, our committee appreciates sincerely not only your stimulating speech, but thanks you for a year of truly dedicated leadership.

"Thank you, Dr. Tschantz."

Members of the committee were the following: Robert M. Inglis, Franklin County; Jasper M. Hedges, Pickaway County; Charles H. McMullen, Ashland County; Emil J. Meckstroth, Erie County; Maurice F. Lieber, Stark County, Chairman.

On motion made and seconded, the House of Delegates by official action approved the report of the Committee on the President's Address.

### Election of President-Elect

The rules were then suspended by permission of the House of Delegates and the House moved to the fifth order of business, the election of the President-Elect.

Dr. Tschantz called for nominations from the floor for a candidate to be elected as President-Elect.

Dr. Horatio T. Pease, Medina County, placed in nomination the name of Dr. Lawrence C. Meredith, Elyria, Councilor of the Eleventh District.

The nomination being seconded, and there being no further nominations, by official action the nominations were closed and **Dr. Meredith was elected President-Elect by acclamation.**

Dr. Meredith was escorted to the rostrum where he spoke briefly to the House of Delegates.

### Election of Councilors

Dr. Fred Berlin, Allen County, as chairman, presented the report of the Nominating Committee. The report was as follows:

#### Second District

As Councilor of the Second District to succeed himself, the committee placed in nomination the name of Dr. Theodore L. Light, Dayton. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Light was declared re-elected Councilor of the Second District for a term of two years, 1965-1966 and 1966-1967.**

#### Fourth District

As Councilor of the Fourth District to succeed himself, the committee placed in nomination the name of Dr. Robert N. Smith, Toledo. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Smith was declared re-elected Councilor of the Fourth District for a term of two years, 1965-1966 and 1966-1967.**

#### Sixth District

As Councilor of the Sixth District to succeed himself, the committee placed in nomination the name of Dr. Edwin R. Westbrook, Warren. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Westbrook was declared re-elected Councilor of the Sixth District for a term of two years, 1965-1966 and 1966-1967.**

#### Eighth District

As Councilor of the Eighth District to succeed himself, the committee placed in nomination the name of Dr. Robert C. Beardsley, Zanesville. The nomination being duly seconded, and there being no further



nominations from the floor, by official action the nominations were closed and Dr. Beardsley was declared re-elected Councilor of the Eighth District for a term of two years, 1965-1966 and 1966-1967.

#### Tenth District

As Councilor of the Tenth District to succeed himself, the committee placed in nomination the name of Dr. Richard L. Fulton, Columbus. The nomination being duly seconded, and there being no further nominations from the floor, by official action the nominations were closed and Dr. Fulton was declared re-elected Councilor of the Tenth District for a term of two years, 1965-1966 and 1966-1967.

#### Eleventh District

As Councilor of the Eleventh District to succeed Dr. Lawrence C. Meredith, Elyria, who was elected President-Elect, Dr. William R. Graham, Huron County, placed in nomination the name of Dr. William R. Schultz, Wooster, to serve for one-year — the unexpired term of Dr. Meredith. The nomination being duly seconded by Dr. Albert B. Huff, Wayne County, and there being no further nominations from the floor, by official action the nominations were closed and Dr. Schultz was declared elected Councilor of the Eleventh District for a term of one year — 1965-1966.

#### AMA Delegates and Alternates

The Nominating Committee then placed in nomination the following for the office of delegate and alternate to the American Medical Association for a term of two years beginning January 1, 1966:

Dr. Edwin H. Artman, Chillicothe, delegate, and Dr. Philip B. Hardymon, Columbus, alternate.

Dr. John H. Budd, Cleveland, delegate, and Dr. P. John Robeck, Cleveland, alternate.

Dr. Richard L. Meiling, Columbus, delegate, and Dr. Robert E. Tschantz, Canton, alternate.

Dr. Charles A. Sebastian, Cincinnati, delegate, and Dr. J. Robert Hudson, Cincinnati, alternate.

There being no further nominations for these offices, and the nominations being duly seconded, by official action the nominations were closed and the nominees were declared elected for two-year terms beginning January 1, 1966.

For a two-year term as delegate to the AMA beginning January 1, 1966, the name of Dr. Frederick P. Osgood, Toledo, was placed in nomination. The nomination being seconded and there being no additional nominations, by official action the nominations were closed and Dr. Osgood was declared elected delegate to the AMA for a two-year term beginning January 1, 1966.

The committee placed in nomination two candidates, Dr. Robert N. Smith, Toledo, and Dr. Jack Schreiber, Youngstown, for the position of Alternate-Delegate to the AMA for a term of two years beginning January 1, 1966. The President instructed

the Committee on Tellers and Judges of Election to conduct a written ballot and Dr. Smith was declared elected for a two-year term as alternate to the AMA, beginning January 1, 1966.

The House then reverted to the third order of business, "Reports of Reference Committees on Resolutions."

#### Report of Resolutions Committee No. 1

Dr. John H. Budd, Cuyahoga County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 considered nine resolutions. Discussion was thorough, vigorous, enlightening and unrestricted. I believe all who wished to testify were heard. The evidence and arguments advanced were presented effectively and convincingly. They were given full and thoughtful consideration by your Committee."

#### RESOLUTION NO. 1

##### Increase in OSMa Dues

(Submitted by The Council of the Ohio State Medical Association)

WHEREAS, At the 1965 Annual Meeting of the Ohio State Medical Association the delegates will act on a resolution to waive dues for members over 70 years of age on their request and such an amendment, if presented, will result in a marked decrease in revenue to the Association; and

WHEREAS, The Association is faced with the situation in which expenses are rising but income is not increasing, making it necessary to include income from previous years to bring the 1965 budget into balance; and

WHEREAS, Ohio is currently one of three state medical associations with the lowest dues in the country; and

WHEREAS, Medicine faces its time of greatest challenge, and has found it necessary to expand existing programs as well as to initiate additional activities;

THEREFORE, BE IT RESOLVED, That the per capita annual dues of the Ohio State Medical Association be increased \$15 effective January 1, 1966, making the total amount of annual dues \$50.

"This resolution presented by The Council of the State Association recommended an increase in OSMa dues. Well prepared testimony in support of this proposal was presented by several members of Council and other officers of the Association. The issue was subjected to a thorough and critical examination and constructive suggestions were offered whereby economies might be effected. It was the opinion of the Reference Committee that the need for increased income is justified and that the continued successful operation of the Association requires approval of the dues increase. The Committee also recommends continuing study of methods and suggestions for economy of operation and that a report on such investigations be made to the House of Delegates at the next Annual Meeting. Particular attention is directed to the fiscal problems of *The Journal*, the increasing costs attendant upon its publication and its difficult competitive position with other medical journals and so-called 'throw-away' publications. We believe that such problems are faced by the majority

of the State Medical Journals and are in no sense a reflection on management or editorial efficiency and excellence. The Committee proposes amendment of the resolution by deletion of two WHEREAS paragraphs. The amended resolution will then read as follows:

**AMENDED RESOLUTION NO. 1**  
Increase in OSMA Dues

WHEREAS, The Ohio State Medical Association is faced with a situation in which expenses are rising without parallel increase in income making it necessary to draw on income from previous years to bring the 1965 budget into balance, and

WHEREAS, As medicine faces its time of greatest challenge, the Association has found it necessary to expand existing programs as well as to initiate additional activities, therefore

BE IT RESOLVED, That the annual per capita dues of the Ohio State Medical Association be increased \$15.00 effective January 1, 1966, making the total amount of annual dues \$50.00.

"Mr. President, I move the adoption of Resolution No. 1 as amended."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 1 be adopted, was approved.

**RESOLUTION NO. 3**  
Osteopathy

(By the Summit County Medical Society)

WHEREAS, In our opinion no uniform and state-wide policy governs professional relations between physicians-members of the Ohio State Medical Association and doctors of osteopathy and that we believe this to be desirable, and

\*WHEREAS, The House of Delegates of the American Medical Association has clearly delegated to the state associations a key responsibility in this field of policy making, and

WHEREAS, There are only about thirteen-hundred licensed doctors of osteopathy in the State of Ohio as compared to approximately eleven-thousand licensed medical doctors, indicating that leadership in this matter should be retained by the Ohio State Medical Association rather than by the Ohio State Osteopathy Association or comparable group, and

WHEREAS, It is our aim to combine into one fellowship all who practice ethical and scientific medicine, therefore

BE IT RESOLVED, That Ohio delegates to the American Medical Association institute proposals calling on the American Medical Association to work toward standardization and accreditation of undergraduate and postgraduate training for doctors of osteopathy directly through its own committees as well as through its representatives and delegates to other accrediting bodies, and

BE IT FURTHER RESOLVED, That this House of Delegates pursuant to the Constitution and Bylaws which require that matters of ethics be referred to Council, request the Council of the Ohio State Medical Association to develop a plan of action for this House to approve or disapprove at its annual meeting in 1966 detailing a program and mechanism to aid the development of customary internships and residencies for doctors of osteopathy who signify their intent to join county and state medical societies, and

BE IT FURTHER RESOLVED, That this plan include procedures for subsequently determining by examination whether or not the individual osteopath graduate is capable in fact of practicing a method of healing founded on a scientific basis, and

BE IT FURTHER RESOLVED, That this plan include provision for inviting all Ohio osteopaths so inclined to voluntarily apply for such training, accreditation and discipline under the principles of medical ethics, and

\*House of Delegates, AMA, 1961.

BE IT FINALLY RESOLVED, That said plan include a schedule of constitutional and bylaws changes and public legislation aimed not only at establishing membership for qualified osteopathic physicians in the Ohio State Medical Association but also designed to bring about a single, licensed, qualified medical profession in the State of Ohio—all this in the best interest of the public.

"With regard to Resolution No. 3, the problems which it identifies and the solutions which it suggests were considered at length. The portion dealing with internship and residencies is dealt with in Amended Resolution No. 17." It is the opinion of the Committee that the other proposals of Resolution No. 3 should not be acted on at this time. Therefore, the Committee recommends that Resolution No. 3 be NOT adopted and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 3 NOT be adopted, was approved.

**RESOLUTION NO. 4**  
Architectural Barriers

(By the Academy of Medicine of Cleveland)

WHEREAS, Public buildings are constructed for the purpose of serving all of the Public, and

WHEREAS, The architectural design of many public buildings includes such things as narrow elevator doors, narrow corridor doors, long steep flights of steps and other things which impede the movement of handicapped persons in and around such public buildings, therefore

BE IT RESOLVED, That this problem be brought to the attention of proper public officials so that new construction and remodeling will include such modification in design so as to make the movement of the handicapped easier.

"Resolution No. 4 deals with the subject of architectural barriers in public buildings. The intent of this resolution is expressed in legislation currently under consideration in the General Assembly of the State. Therefore, Resolution No. 4 in the following amended form is presented."

**AMENDED RESOLUTION NO. 4**  
Architectural Barriers

WHEREAS, Public buildings are constructed for the purpose of serving all of the Public, and

WHEREAS, The architectural design of many public buildings includes such things as narrow elevator doors, narrow corridor doors, long steep flights of steps and other things which impede the movement of handicapped persons in and around such public buildings, and

WHEREAS, S. B. No. 124, which has been introduced in the General Assembly, provides standards, rules and regulations for the construction of public buildings so as to facilitate their free and unrestricted use by the handicapped, therefore

BE IT RESOLVED, That the Ohio State Medical Association record its support of this legislation and through its executive staff encourage passage of S. B. No. 124.

"Mr. President, I move the adoption of Resolution No. 4 as amended."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 4 be adopted, was approved.

**RESOLUTION NO. 8**  
Exemption from OSMA Dues

(By the Academy of Medicine of Cleveland)

WHEREAS, Some physician members of the Ohio State



Medical Association may experience drastic financial emergencies due to family illness, accident, or other cause, and

WHEREAS, These members may earnestly desire to retain membership in their Ohio State Medical Association but find payment of the regular dues constitutes a genuine financial hardship, and

WHEREAS, These members may not qualify for dues exemption under paragraph 2 of Section 1 of Chapter 2 of the Constitution and Bylaws of the Ohio State Medical Association, therefore

BE IT RESOLVED, That, in addition to the present provisions regarding dues exemptions as provided in paragraph 2, Section 1, Chapter 2 of the Constitution and Bylaws of the Ohio State Medical Association, an appropriate amendment be prepared by the Legal Counsel, under the supervision of The Council of the Association, to incorporate the following:

A member of the Ohio State Medical Association for whom payment of the regular dues constitutes a financial hardship may be granted an adjustment of dues, for a specified period of time, to meet his specific problem upon approval of the Council of the Ohio State Medical Association provided:

(a) That such member present a written formal request for dues adjustment, and

(b) That his request has been approved by his local society and certified to the Ohio State Medical Association by the Secretary-Treasurer of the local society.

"Resolution No. 8 presented by the Academy of Medicine of Cleveland provides for dues adjustment on the basis of financial hardship. The weight of testimony presented before the Committee favored the intent of this resolution. However, inasmuch as the resolution involves a change in the Constitution and Bylaws it is necessary that such amendment be prepared and submitted to the House of Delegates at the next Annual Meeting. The Committee recommends a minor change in the Resolved portion of the resolution and the amended resolution reads as follows:"

#### AMENDED RESOLUTION NO. 8

##### Exemption from OSMA Dues

WHEREAS, Some physician members of the Ohio State Medical Association may experience financial emergencies due to family illness, accident, or other cause, and

WHEREAS, These members may earnestly desire to retain membership in their Ohio State Medical Association but find payment of the regular dues constitutes a genuine financial hardship, and

WHEREAS, These members may not qualify for dues exemption under paragraph 2 of Section 1 of Chapter 2 of the Constitution and Bylaws of the Ohio State Medical Association, therefore

BE IT RESOLVED, That, in addition to the present provisions regarding dues exemptions as provided in paragraph 2, Section 1, Chapter 2 of the Constitution and Bylaws of the Ohio State Medical Association, an appropriate amendment be prepared by the legal counsel, under the supervision of The Council of the Association, to incorporate the following:

A member of the Ohio State Medical Association for whom payment of the regular dues constitutes a financial hardship may be granted such adjustment of dues, and for such period of time as may be approved by The Council of the Ohio State Medical Association provided:

(a) That such member present a written formal request for dues adjustment, and

(b) That his request has been approved by his component society and certified to the Ohio State Medical



*At the final session of the House of Delegates, the gavel is passed from Outgoing President Robert E. Tschantz, left, to Incoming President Henry A. Crawford.*



*Dr. Lawrence C. Meredith is presented before the House of Delegates following action naming him President-Elect of the Association. President Tschantz, at the rostrum, made the presentation.*



*George H. Saville, right, was honored for his years of service to the Association at the first session of the House of Delegates and presented a watch engraved, "Scottie—30 years—OSMA." Making the presentation is President Robert E. Tschantz.*

Association by the Secretary-Treasurer or other appropriate officer of the said society."

"Mr. President, I move the adoption of Resolution No. 8 as amended."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 8 be adopted, was approved.

#### RESOLUTION NO. 11

Amendments to the Ohio Medical Practice Act  
(By the Academy of Medicine of Cincinnati)

WHEREAS, Section 4731.51 of the Ohio Revised Code authorizes podiatrists to treat ailments of hand or foot, and

WHEREAS, Podiatrists are not trained and qualified to perform hand surgery, and

WHEREAS, Other sections of the Medical Practice Act should be amended, and

WHEREAS, Efforts to obtain injunctive relief have been defeated by the General Assembly, and

WHEREAS, Enforcement of the law against second offenders who violate the Medical Practice Act have little regard for the subsequent convictions and fines imposed are not severe enough to establish respect for enforcement of said Medical Practice Act, and

WHEREAS, Illegal practices have caused irreparable damage to the public through quackery, and

WHEREAS, Limited practitioners licensed by the Ohio State Medical Board have not rightfully used their licenses in certain cases, and

WHEREAS, The effective enforcement of the Medical Practice Act is deterred because offices of limited practitioners are not open for regular inspection, and

WHEREAS, The Ohio State Medical Board is not given the necessary authority to effectively enforce its rules and laws against undesirable practitioners both limited and general, and

WHEREAS, The Attorney General of the State of Ohio has refused to defend inspectors when suits are filed against them personally, for enforcement of law within the scope of their authority to the making appropriate arrests while in the performance of their duties; therefore,

BE IT RESOLVED, That Section 4731.51 of the Ohio Revised Code be revised by deleting the words "chiroprody" and "hand," and

BE IT FURTHER RESOLVED, That the penalty section of 4731.99, Ohio Revised Code, provide severe penalties for second and subsequent offenders, and

BE IT FURTHER RESOLVED, That all licenses of limited practitioners expire on an annual basis and said licenses be subject to renewal; and

BE IT FURTHER RESOLVED, That the Ohio State Medical Board be given the necessary authority to enforce its rules against undesirable practitioners, including the right of inspection during reasonable hours, and

BE IT FURTHER RESOLVED, That the medical inspectors of the State of Ohio receive the protection of the State through representation by the Attorney General for the State of Ohio.

"Resolution No. 11 proposes amendments to the Ohio Medical Practice Act including recommendations for reinforcement and strengthening of the investigative arm of the State Medical Board, more strict enforcement of the law as it is now written, protective mechanisms against legal liability of State Medical Inspectors in the exercise of their duties, and certain modifications of the provisions of the Act. The Committee realizes the vital importance of

thorough study of these proposals and the desirability of their effective implementation. Because of the complexity of the issues involved, the Committee recommends that Resolution No. 11 be referred to Council for consideration and appropriate action, and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 11 be referred to The Council for consideration and appropriate action, was approved.

#### RESOLUTION NO. 13

To Authorize Physicians and Pharmacists to Prescribe and Provide Contraceptive Information and Materials  
(By the Academy of Medicine of Cleveland)

WHEREAS, Physicians at times recommend the limitation of family size or the interval spacing of conception and pregnancy for the life and health of the mother, and

WHEREAS, Methods of such control are now available which assure family spacing with great safety, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct the Council and Executive Staff to urge the Ohio Legislature to amend the Ohio Revised Code so as to separate regulations concerning contraceptive information and materials from the laws on obscenity, and to authorize and permit physicians and pharmacists in their legitimate enterprise to sell, give away, and keep for sale or gratuitous distribution drugs, nostrums, and appliances for preventing conception.

"Resolution No. 13, presented by the Academy of Medicine of Cleveland, is concerned with legalizing the dissemination of contraceptive information and materials by physicians and other health agencies. In the opinion of the Committee a bill currently before the Ohio General Assembly would, if slightly amended, fulfill the intent of this resolution. Arrangements have been made for presentation of the necessary amendments. Therefore, the Committee presents an Amended Resolution No. 13 which reads as follows:

#### AMENDED RESOLUTION NO. 13

To Authorize Physicians to Prescribe and Dispense and Pharmacists to Provide on Prescription Contraceptive Information and Materials

WHEREAS, Physicians at times recommend the limitation of family size or the interval spacing of conception and pregnancy for the life and health of the mother, and

WHEREAS, Methods of such control are now available which assure family spacing with great safety, and

WHEREAS, H. B. No. 120, with appropriate amendments, removes the legal barriers preventing physicians from disseminating contraceptive information and materials and restraining pharmacists from complying with prescriptions for such items, therefore

BE IT RESOLVED, That the Ohio State Medical Association support H. B. No. 120 and through its executive staff encourage the passage of this bill, appropriately amended by the Ohio Legislature.

"Mr. President, I move the adoption of Resolution No. 13 as amended."

The title of the amended resolution was amended on the floor of the House to read as follows: "To Authorize Physicians to Prescribe and Dispense and Pharmacists to Provide on Prescription Contraceptive Information and Materials."

Following the adoption of the floor amendment,



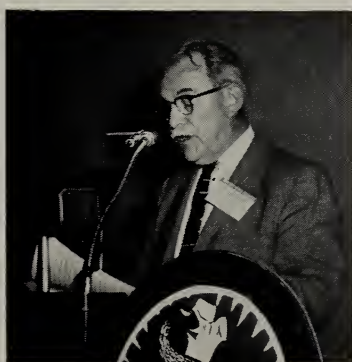
# Annual Meeting Camera Highlights



*Past-Presidents of the Association are shown here at the dinner-meeting of The Council, with former OSMA Executive Secretaries. Front row, from left, are: Dr. Paul A. Davis, Dr. Carl A. Lincke, Dr. A. A. Brindley, Mr. Charles S. Nelson, Dr. Robert E. Tschantz, Mr. George H. Saville, Dr. Robert S. Martin and Dr. Merrill D. Prugh. Standing, from left, are Dr. Frank H. Mayfield, Dr. George J. Hamwi, Dr. Harve M. Clodfelter, Dr. George W. Petznick, Dr. Edwin H. Artman, Dr. Richard L. Meiling, Dr. Charles L. Hudson, and Dr. H. T. Pease.*



*Delegates of County Medical Societies, alternates, officers of the Association and others who attended in an official capacity are shown in this view of part of the House of Delegates which met twice during the 1965 Annual Meeting.*



*Chairman of the three Resolutions Committees are shown as they presented reports of their committees before the House of Delegates. From left are, Dr. J. Martin Byers, Greenfield, chairman of Resolutions Committee No. 2; Dr. Frederick P. Osgood, Toledo, chairman of Resolutions Committee No. 3; and Dr. John H. Budd, Cleveland, chairman of Resolutions Committee No. 1.*

by official action of the House of Delegates, the amended resolution was adopted as amended.

#### RESOLUTION NO. 14

To Permit City, County and State Health Departments to Suggest, Prescribe or Make Available Information and Materials for Contraception

(By the Academy of Medicine of Cleveland)

WHEREAS, Unchecked human reproduction already poses a grave threat to the health and welfare of society both in the United States and elsewhere, and

WHEREAS, Pregnancy sometimes can and does threaten the life and well-being of individual mothers, and

WHEREAS, Numerous and undesired pregnancies may result in deterioration of family life, a life of misery for unwanted dependent children, and intensification of social problems of disease, delinquency, and crime, and

WHEREAS, There exist safe means of a variety sufficient to be compatible with varying religious beliefs and mores, therefore

BE IT RESOLVED, That the Ohio State Medical Association does hereby urge such revision of Ohio laws, statutes, and departmental directives as may be necessary to permit and require physicians or public health officers employed by the Department of Health of the State of Ohio and of departments of health of counties, cities, or districts within the State of Ohio to make available information or materials for family planning and contraception consistent with the religious beliefs and mores of the patient, upon request by the patient or upon the initiative of the physician or health officer when in such officers' professional opinion such information is necessary for the health and welfare of the patient, or of the community, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association hereby urges component county medical societies to support such legislation and policy directive as will ensure comparable action by health authorities within each county.

"Resolution No. 14 proposes removal of legal obstacles to dissemination of information and materials for contraception by City, County and State Health Departments. It is the opinion of the Committee that the passage of H. B. No. 120, in amended form, will promote in part the objectives of this resolution. The Committee recommends, in addition, an Amended Resolution No. 14 which reads as follows:

#### AMENDED RESOLUTION NO. 14

To Permit City, County and State Health Departments to Suggest, Prescribe or Make Available Information and Materials for Contraception

WHEREAS, Unchecked human reproduction already poses a grave threat to the health and welfare of society both in the United States and elsewhere, and

WHEREAS, Pregnancy sometimes can and does threaten the life and well-being of individual mothers, and

WHEREAS, Numerous and undesired pregnancies may result in deterioration of family life, a life of misery for unwanted dependent children, and intensification of social problems of disease, delinquency, and crime, and

WHEREAS, There exist safe methods of contraception sufficient in number and variety to be compatible with varying religious beliefs and mores, therefore

BE IT RESOLVED, That the Ohio State Medical Association in addition to supporting H. B. No. 120, appropriately amended, also urge such revision of Ohio laws, statutes and departmental directives as may be necessary,

1. To permit physicians employed by the Department of Health and the State of Ohio and by departments of health of counties, cities or districts within the State of Ohio to make available information or materials for family planning and contraception consistent with the religious beliefs and mores of the patient, and

2. To require all public departments providing social and

health services to adopt a policy on family planning and birth control which enables its staff to make referrals of patients to appropriate medical resources to meet their needs for birth control and planning for parenthood."

Mr. President, I move the adoption of Resolution No. 14 as amended.

By official action, the recommendation of the committee, namely, that Amended Resolution No. 14 be adopted, was approved.

#### RESOLUTION NO. 16

OSMA Dues Exemption for Members  
70 Years of Age and Over

(By The Council, Ohio State Medical Association)

WHEREAS, At the 1964 Annual Meeting of this Association the House of Delegates adopted substitute resolution No. 5 directing The Council to draft an appropriate amendment to the Bylaws of the Association so as to provide for the exemption from dues and assessments of members who are seventy (70) years of age or over, and

WHEREAS, The second paragraph of the present Section 1 of Chapter 2 of the Bylaws provides exemption from dues and assessments only to those doctors of medicine who have retired from "active practice because of age or disability," said present paragraph 2 reading as follows:

"Provided, however, that a doctor of medicine who is not engaged in active practice because of age or disability and who was a member in good standing of this Association at the time of his retirement from active practice shall be exempt from the payment of dues and assessments in this Association, provided he requests such exemption and such request is approved in writing by the secretary-treasurer of his component society.", and

WHEREAS, It is deemed necessary and advisable to amend the second paragraph of Section 1 of Chapter 2 in order to provide for the exemption from Association dues of those members who are seventy (70) years of age or over;

NOW, THEREFORE, BE IT RESOLVED, That the second paragraph of Section 1 of Chapter 2 of the Bylaws of the Ohio State Medical Association be, and the same hereby is, amended to read as follows:

Provided, however, that any doctor of medicine (a) who has been engaged in active practice in Ohio for at least ten (10) consecutive years, and has attained the age of seventy (70) years or more, and has been a member in good standing of this Association for at least ten (10) consecutive years, or (b) who has ceased or shall have ceased to be engaged in active practice because of age or disability, and who is a member in good standing of this Association, may request, in writing, exemption from the payment of dues and assessments in this Association; and upon the approval, in writing, of such request by the secretary of the component society of which such doctor of medicine is then a member in good standing and the filing of such written approval with the Executive Secretary of this Association, such doctor of medicine shall be exempt from the payment of all dues and assessments accruing on or after the first day of January next succeeding the date of the filing of such written approval with the Executive Secretary of this Association.

"Resolution No. 16 proposes exemption from Ohio State Medical Association dues when requested for members 70 years of age and over. This resolution, submitted by The Council and prepared by the Association's legal counsel, is an amendment to the Constitution whereby members who are 70 years of age or over may be exempted from dues upon request. It was pointed out by several who testified that it is the philosophy of this Association that need rather than age be a criterion for eligibility for such a benefit. The Committee is in agreement with these



views and therefore, the Committee recommends that Resolution No. 16 be not adopted and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 16 NOT be adopted, was approved.

#### RESOLUTION NO. 17

Re: Osteopathic Physicians

(By the Portage County Medical Society)

WHEREAS, The American Medical Association has seen fit to make ethical the association between its members and those osteopaths who practice "Scientific Medicine," and

WHEREAS, The Ohio State Medical Association has granted the right to County Societies to accept as associate members those osteopaths who do practice "Scientific Medicine," and

WHEREAS, The phrase "Scientific Medicine" fails to clearly classify an individual osteopath, future attempts to evaluate an osteopathic physician will remain difficult because his own training programs have not received accreditation by the appropriate committees of the American Medical Association, and

WHEREAS, If it were possible for the graduate of an osteopathic school to receive internship and residency training in an AMA approved program, he could then be accepted for his demonstrated abilities to practice scientific medicine. Be it therefore

RESOLVED, That the Ohio Delegation to the American Medical Association enter and support a resolution to make possible intern and residency training for the properly qualified osteopathic physician in existing AMA approved hospital programs.

Resolution No. 3 and Resolution No. 17 presented respectively by Summit County and Portage County Medical Societies were concerned with the professional relationship between doctors of medicine and doctors of osteopathy and suggestions whereby the policy pronouncements of the American Medical Association might be implemented.

Resolution No. 17 proposes to make possible intern and residency training of properly qualified osteopathic physicians in AMA approved hospital programs. A modification of the language of the resolve is recommended so that the Amended Resolution No. 17 reads as follows:

#### AMENDED RESOLUTION NO. 17

Osteopathic Physicians

WHEREAS, The American Medical Association has seen fit to make ethical the association between its members and those osteopaths who practice "Scientific Medicine," and

WHEREAS, The Ohio State Medical Association has granted the right to County Societies to accept as associate members those osteopaths who do practice "Scientific Medicine," and

WHEREAS, The evaluation of an osteopathic physician will remain difficult because his own training programs have not received accreditation by the appropriate committees of the American Medical Association, and

WHEREAS, If it were possible for the graduate of an osteopathic school to receive internship and residency training in an AMA approved program, he could then be judged on the basis of his demonstrated abilities to practice scientific medicine, and

WHEREAS, Graduates of schools of osteopathy who do not hold M.D. degrees are not eligible for appointment to internships or residencies approved by the Council on Medical Education of the AMA,

THEREFORE, BE IT RESOLVED, that the Ohio Delegation to the AMA present and support a resolution re-



*Outgoing President Robert E. Tschantz and Mrs. Tschantz receive a silver engraved tray as a token of appreciation from the Association at the final meeting of the House of Delegates. Past-President H. T. Pease, right, made the presentation.*



*Officially opening the House of Delegates is Dr. John R. Huston, President of the host Academy of Medicine of Columbus and Franklin County.*



*One of the first Official performances of Incoming President Henry A. Crawford, left, was to pin the Past-President's button on Outgoing President Robert E. Tschantz.*

questing the House of Delegates of the AMA to instruct the Council on Medical Education to develop a method whereby qualifications of osteopathic physicians may be evaluated in order to determine eligibility for intern and residency training in AMA approved hospital programs, without jeopardizing the hospital's accreditation status.

Mr. President, I move the adoption of Amended Resolution No. 17.

After a discussion of the motion, by official action the final paragraph of the resolution was amended to read as follows (new material in italics):

THEREFORE, BE IT RESOLVED, That the Ohio Delegation to the AMA present and support a resolution requesting the House of Delegates of the AMA to instruct the Council on Medical Education to develop a method whereby qualifications of osteopathic physicians *who are willing to subscribe to the Principles of Medical Ethics of the American Medical Association and who express the wish to join a component medical society*, may be evaluated in order to determine eligibility for intern and residency training in AMA approved hospital programs, without jeopardizing the hospital's accreditation status.

By official action, amended Resolution No. 17, subsequently amended on the floor of the House, was adopted by a vote of 73 to 60. It reads as follows:

#### AMENDED RESOLUTION NO. 17

##### Osteopathic Physicians

(As amended on the floor of the House of Delegates)

WHEREAS, The American Medical Association has seen fit to make ethical the association between its members and those osteopaths who practice "Scientific Medicine," and

WHEREAS, The Ohio State Medical Association has granted the right to County Societies to accept as associate members those osteopaths who do practice "Scientific Medicine," and

WHEREAS, The evaluation of an osteopathic physician will remain difficult because his own training programs have not received accreditation by the appropriate committee of the American Medical Association, and

WHEREAS, If it were possible for the graduate of an osteopathic school to receive internship and residency training in an AMA approved program, he could then be judged on the basis of his demonstrated abilities to practice scientific medicine, and

WHEREAS, Graduates of schools of osteopathy who do not hold M.D. degrees are not eligible for appointment to internships or residencies approved by the Council on Medical Education of the AMA,

THEREFORE, BE IT RESOLVED, That the Ohio Delegation to the AMA present and support a resolution requesting the House of Delegates of the AMA to instruct the Council on Medical Education to develop a method whereby qualifications of osteopathic physicians who are willing to subscribe to the principles of medical ethics of the American Medical Association and who express the wish to join a component county medical society, may be evaluated in order to determine eligibility for intern and residency training in AMA approved hospital programs, without jeopardizing the hospital's accreditation status.

Dr. Budd then moved the adoption of the Report of Resolutions Committee No. 1 as a whole, as amended. The motion was seconded and by official action was adopted by the House of Delegates.

#### Committee Thanked

"The Committee is grateful for the testimony of all

who appeared and the courtesy displayed by all discussants. As Chairman, I am deeply appreciative of the unwavering patience, stimulating wisdom and discriminating vision of the Committee members, all of whom contributed greatly to the preparation of this report. Members of the committee were as follows: John J. Cranley, Hamilton County; Maurice M. Kane, Darke County; Donald R. Brumley, Hancock County; V. William Wagner, Ottawa County; G. E. DeCicco, Mahoning County; R. E. Rinderknecht, Tuscarawas County; J. L. Kraker, Fairfield County; Harry Nenni, Lawrence County; Homer A. Anderson, Franklin County; A. B. Huff, Wayne County; John H. Budd, Cuyahoga County, Chairman."

#### Report of Resolutions Committee No. 2

Dr. J. Martin Byers, Highland County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"I have the privilege of presenting to the House of Delegates the following report of Resolutions Committee No. 2. This committee had eight resolutions for consideration."

#### RESOLUTION NO. 2

##### Environmental Heat and Athletics

(By the Ashland County Medical Society)

WHEREAS, Football practice in Ohio high schools and colleges is conducted during August and September when the heat and humidity are significantly high, and

WHEREAS, Heat stroke has been the cause of avoidable fatalities in football practices in Ohio and the nation each year, and

WHEREAS, Heat stroke deaths are preventable if proper precautions are taken, now therefore,

BE IT RESOLVED, That each county medical society take an active role each summer to provide medical leadership at the school level in the education of coaching staffs and, furthermore, the society should make certain that there is direct supervision of personnel concerned with assessing heat and humidity on the football field in order that practice schedules may be altered when the condition warrants it, and be it further

RESOLVED, That a preseason conditioning program be encouraged, including water and salt available on the field; that a program be instituted at each school for the prevention of problems with environmental heat, and be it further

RESOLVED, That the Ohio delegation to the American Medical Association introduce this resolution at the next session of the House of Delegates of the American Medical Association.

"This resolution presented much discussion and was amended as follows:

#### AMENDED RESOLUTION NO. 2

##### Environmental Heat and Athletics

WHEREAS, Football practice in Ohio high schools and colleges is conducted during August and September when the heat and humidity are significantly high, and

WHEREAS, Heat stroke has been one of the causes of avoidable fatalities in football practices and games in Ohio and the nation each year and is preventable, if proper precautions are taken, therefore,

BE IT RESOLVED, That each county medical society take an active role each summer to provide medical leadership at the school level in the education of coaching staffs and, furthermore, the society should make certain that there is direct supervision of personnel concerned with assessing heat and humidity on the football field in order that prac-



tice schedules or games may be altered when the condition warrants it, and be it further

RESOLVED, That a preseason conditioning program be encouraged, including water and salt available on the field; and that a program be instituted at each school for the prevention of problems with environmental heat.

"The committee unanimously recommends the adoption of this amended resolution and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 2 be adopted, was approved.

#### RESOLUTION NO. 5

##### Mental Health Program

(By the Summit County Medical Society)

WHEREAS, Physicians have long been leaders in the field of treatment and prevention, of mental illness, and that they alone are capable of providing complete, comprehensive care, and

WHEREAS, The American Medical Association has identified mental illness as America's most pressing and complex health problem and that every physician, regardless of type of practice, has an important stake in improving our mental health knowledge and resources, and

WHEREAS, The American Medical Association in its First and Second Congresses on Mental Illness and Health and in its Statement of Principles on Mental Health, has emphasized the need for medical societies and physicians at every level to promote community mental health programs for treatment and prevention of mental illness, and

WHEREAS, The Ohio State Medical Association in its 1964 delegate assembly reaffirmed the leadership role of the physician in mental health planning programs by its passage of resolution No. 14, therefore

BE IT RESOLVED, That the 1965 delegate assembly acknowledge the efforts of the Committee on Mental Health of the OSMA in establishing a program, and

BE IT FURTHER RESOLVED, That the Council continue to support the Committee on Mental Health so as to effectively involve the component societies in active participation in community mental health planning and programs, and

BE IT FURTHER RESOLVED, That to accomplish such participation, a state-wide conference of county mental health committee chairmen and officers, be held within the current year to provide information on community mental health services and to effect a coordinated effort on the part of component societies.

"Resolution No. 5, submitted by the delegates from Summit County, was next considered. Again in the committee room there was a lively discussion concerning this resolution. After a thorough discussion of this resolution, the committee recommends that the last paragraph be amended. Amended Resolution No. 5 reads as follows:"

#### AMENDED RESOLUTION NO. 5

##### Mental Health Program

WHEREAS, Physicians have long been leaders in the field of treatment and prevention of mental illness, and are capable of providing complete, comprehensive care, and

WHEREAS, The American Medical Association has identified mental illness as America's most pressing and complex health problem and that every physician, regardless of type of practice, has an important stake in improving our mental health knowledge and resources, and

WHEREAS, The American Medical Association in its First and Second Congresses on Mental Illness and Health

and in its Statement of Principles on Mental Health, has emphasized the need for medical societies and physicians at every level to promote community mental health programs for treatment and prevention of mental illness, and

WHEREAS, The Ohio State Medical Association in its 1964 delegate assembly reaffirmed the leadership role of the physician in mental health planning programs by its passage of Resolution No. 14, therefore

BE IT RESOLVED, That the 1965 delegate assembly acknowledge the efforts of the Committee on Mental Health of the Ohio State Medical Association in establishing a program, and

BE IT FURTHER RESOLVED, That the Council continue to support the Committee on Mental Health so as to effectively involve the component societies in active participation in community mental health planning and programs, and

BE IT FURTHER RESOLVED, That to accomplish such participation, a state-wide conference of county medical society officers and mental health committee chairmen be held within the current year to provide information on community mental health services and to effect a coordinated effort on the part of component societies.

"The committee unanimously recommends that this resolution, as amended, be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 5 be adopted, was approved.

#### RESOLUTION NO. 6

##### Need for General Practitioners

(By the Huron County Medical Society)

WHEREAS, There has been a steady decline in the number of medical doctors entering general practice in the past several years; and

WHEREAS, The population steadily continues to increase thus the relative general practitioner-population ratio continues to decline; and

WHEREAS, The medical schools continue to encourage more medical doctors to enter research and specialty fields; and

WHEREAS, The rural, suburban and small community areas are suffering most from a lack of qualified medical doctor generalists; and

WHEREAS, This need is becoming filled by members of the other healing arts; and

WHEREAS, The public image of the medical profession is suffering already, therefore

BE IT RESOLVED, That the Ohio State Medical Association go on record as favoring and encouraging a strong drive to influence the medical schools of Ohio to encourage more young medical doctors to enter into general practice and honor this group with dignity and respect.

"Resolution No. 6, submitted by the delegate from Huron County, and Resolution No. 15, submitted by the delegates from Mahoning County, bearing the same titles, Need for General Practitioners, were considered together.

"The committee feels that this problem of encouraging recent graduates of medical schools to enter general practice is a very pressing one and the committee recognizes the fact that the Committee on Rural Health, the Committee on Education and the Joint Committee on Family Practice have been working steadfastly to encourage recent graduates to

enter general practice of medicine. Therefore, the committee recommends that Resolution No. 6 be amended by deleting the last WHEREAS and amending the resolve portion of this resolution. Amended Resolution No. 6 reads as follows:"

#### AMENDED RESOLUTION NO. 6 Need for General Practitioners

WHEREAS, There has been a steady decline in the number of medical doctors entering general practice in the past several years; and

WHEREAS, The population steadily continues to increase thus the relative general practitioner-population ratio continues to decline; and

WHEREAS, The medical schools continue to encourage more medical doctors to enter research and specialty fields; and

WHEREAS, The rural, suburban and small community areas are suffering most from a lack of qualified medical doctor generalists; and

WHEREAS, This need is becoming filled by members of the other healing arts; therefore

BE IT RESOLVED, That the Ohio State Medical Association continue its strong drive to influence the medical schools of Ohio to encourage more young medical doctors to enter into general practice.

"The committee recommended the adoption of Resolution No. 6, as amended, and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 6 be adopted, was approved.

#### RESOLUTION NO. 7

Blue Shield's (OMI) Association With Blue Cross Plans  
(By the Summit County Medical Society)

WHEREAS, For many years subscribers have identified the Blue Shield Program with the Blue Cross Plans in Ohio, and

WHEREAS, Our Blue Shield Plan itself has now expressed concern similar to that felt for many years by this county medical society over the many misconceptions and misunderstandings in the minds of these subscribers, and

WHEREAS, The public as a whole and even many physicians do not clearly separate the two groups in their thinking, and

WHEREAS, These two companies are separately owned and governed, cover totally different areas of medical expense and oftentimes may represent conflicting philosophies of prepaid health insurance, therefore

BE IT RESOLVED, That the administrative duties performed by the seven Blue Cross Plans in Ohio for our Blue Shield Program (OMI) including the issuance, distribution, servicing and particularly the sales of Blue Shield (OMI) contracts be performed as of January 1, 1966 by Blue Shield itself.

"Discussion of this resolution brought forward much testimony concerning the management of Blue Cross and Ohio Medical Indemnity, Inc., their inter-relationship and their philosophies concerning payment for health services. It was generally agreed that there is much confusion concerning the scope and coverage of the two corporations. While recognizing the different areas of coverage and the sometimes different philosophies, the committee feels that a separation of the administrative duties as proposed by this resolution would cause added administrative costs for both plans and would adversely affect the necessary liaison between Blue Cross Plans and Blue

Shield (OMI) in the sale of contracts, and would do relatively little to resolve the confusion already present in the minds of the subscribers, the plans having been so closely associated over a twenty-year period in Ohio.

"In the opinion of the committee more would be accomplished by a continued program of information and education by Ohio Medical Indemnity, Inc., concerning its place in the field of health insurance. For these reasons, the committee recommends that Resolution No. 7 not be adopted and, Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 7 NOT be adopted, was approved.

#### RESOLUTION NO. 10

Uniform Policy for Ohio Medical Indemnity Contract  
(By Academy of Medicine of Cincinnati)

WHEREAS, The practice of radiology has been acknowledged as the practice of medicine by County Medical Societies, State Societies and the American Medical Association, and

WHEREAS, Blue Cross has been paying hospitals for the taking of x-rays when such x-rays could be taken in the office of the physician if payment were made by Blue Shield for radiologic services, and

WHEREAS, Payments are made by Ohio Medical Indemnity, Inc., under the Comprehensive Contract, and

WHEREAS, Payments are denied to physicians under the Standard and other contracts of Ohio Medical Indemnity, Inc., which are sold in conjunction with Blue Cross in many Ohio counties, and

WHEREAS, The physician can perform a convenient and economic service for patients, and

WHEREAS, The practice of radiology should not be hindered by the policies on certain Blue Shield prepayment plans, therefore

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association adopt a uniform policy for all contracts issued by Ohio Medical Indemnity, Inc., which will provide for payment to the physician when services can be rendered by him in the office and billed to the patient for payment under Blue Shield contracts.

"The discussion of this resolution was prolonged and informative and at times heated. The committee as a whole was indeed in sympathy with the intent of the resolution, but in view of the fact that a major portion of this resolution's intent concerning certain professional medical services is covered in Resolution No. 19 and that X-Ray, BMR and EKG coverages are available in the comprehensive contract as well as available as a rider to all other contracts, including the standard contract offered by Ohio Medical Indemnity, Inc., the committee unanimously recommends that the resolution not be adopted and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 10 NOT be adopted, was approved.

"The committee further urges that the Board of Directors of Ohio Medical Indemnity, Inc., continue to publicize to the doctors of the State of Ohio and to contract holders the availability of this coverage



and to continue to promote the sale of this available coverage."

#### RESOLUTION NO. 12

Review of Fee Schedules for Agencies of the State of Ohio

(By the Academy of Medicine of Cincinnati)

WHEREAS, It has been represented in a reference committee at a previous meeting of the House of Delegates that periodic reviews of fee schedules for agencies of the State of Ohio have been regularly conducted, and

WHEREAS, Specialty organizations in the State and individual members of the Ohio State Medical Association have made frequent inquiries about reviews of the schedules of State agencies, and

WHEREAS, Delegates representing the Academy of Medicine of Cincinnati agreed to withdraw a previous resolution which purported to adopt a regular review of fee schedules, and

WHEREAS, There has been considerable delay in reviewing the schedules of agencies of the State of Ohio; therefore,

BE IT RESOLVED, That the House of Delegates adopt as a policy a routine periodic review (preferably every two years) of fee schedules of agencies of the State of Ohio, including the Division of Aid for the Aged, Welfare and Workmen's Compensation, and

BE IT FURTHER RESOLVED, That the revised schedules be presented to the appropriate agencies of the State of Ohio.

"After a very informative discussion concerning this resolution and a review of fee schedules for agencies of the State of Ohio, the committee presents the following amended resolution:

#### AMENDED RESOLUTION NO. 12

Review of Fee Schedules for Agencies of the State of Ohio

WHEREAS, It has been stated that periodic reviews of fee schedules for agencies of the State of Ohio have been regularly conducted, and

WHEREAS, Certain members and organizations within the Ohio State Medical Association have made frequent inquiries of state agencies and

WHEREAS, If periodic reviews are done then this information is not adequately disseminated to members of the Ohio State Medical Association, now therefore

BE IT RESOLVED, That the appropriate committees of the Ohio State Medical Association continue routine periodic reviews (preferably every two years) of fee schedules of agencies of the State of Ohio and

BE IT FURTHER RESOLVED, That the results of these periodic reviews be widely disseminated through the publications of the Ohio State Medical Association.

"The committee unanimously recommends the adoption of this resolution as amended, and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 12 be adopted, was approved.

#### RESOLUTION NO. 15

Need for General Practitioners

(By Mahoning County Medical Society)

WHEREAS, The number of communities lacking the services of a physician has been increasing each year; and

WHEREAS, The supply of physicians in this country has become a matter of concern to many people; and

WHEREAS, There may be a relative oversupply of certain specialists in some of our larger cities; and

WHEREAS, There is a growing need for more general or family physicians; and

WHEREAS, Many young physicians choose a specialty while in medical school before really having had an opportunity to survey the entire field of medicine and before

ascertaining that another field might be more interesting and offer greater satisfaction, thereby making a better practitioner of the specialty of his more mature choice; and

WHEREAS, The teaching of interns and nurses could be more effectively performed by residents of experience and maturity; and

WHEREAS, The medical profession should do all within its power to meet the demand of the general public; therefore be it

RESOLVED, That the American Medical Association strongly urge the Joint Commission on Accreditation of Hospitals to encourage applicants for residency training in the various specialties to have several years of general practice before undertaking specialty training.

"In consideration of Resolution No. 15 your committee felt that coercing or demanding that recent graduates of medical schools perform several years of general practice before taking specialty training would, indeed, defeat the intent of this resolution, namely, getting more graduates of medical schools to enter into general practice. Therefore, this committee recommends that Resolution No. 15 not be adopted and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 15 NOT be adopted, was approved.

#### RESOLUTION NO. 18

Nominating Committee Procedures and Nominations  
For the Office of President-Elect

WHEREAS, At the 1964 Annual Meeting of this Association, the House of Delegates adopted recommendations of the Nominating Committee asking that the Council of the Ohio State Medical Association make a study of the provisions of Chapter 5 of the Bylaws with a view of recommending such changes therein as may be necessary or advisable in order to define clearly the scope, function and authority of the Committee on Nominations and to prescribe an orderly procedure for the carrying out of the committee's assignments and responsibilities, and

WHEREAS, At the same meeting the House of Delegates adopted Amended Resolution No. 3, directing the President of the Ohio State Medical Association to appoint a committee to study a method or methods of announcing a nominee or nominees for the office of President-Elect prior to the time of the Annual Meeting, and

WHEREAS, The Council and the committee were instructed to report their findings at the Next Annual Meeting of the Ohio State Medical Association, and

WHEREAS, Both matters were assigned to an Ad Hoc Committee on Revisions of the OSMA Constitution and Bylaws for implementation, and

WHEREAS, Such committee has studied the instructions of the House of Delegates and has developed suggested amendments to carry out the wishes of the House, therefore

BE IT RESOLVED, That the following amended Section 1 of Chapter 5 of the Bylaws of the Ohio State Medical Association be submitted for the consideration of the House of Delegates:

#### CHAPTER 5

##### NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. On the first day of the annual meeting the House of Delegates shall elect a Committee on Nominations consisting of one delegate from each councilor district. The chairmanship of the Nominating Committee shall be rotated in numerical order annually among the Councilor district representatives on the committee. The Committee on Nominations shall report to the House of Delegates a ticket containing the name of one or more members for each of the offices to be filled at that annual meeting except that of President-Elect. Prior to

selecting a ticket the Committee shall permit the opportunity for hearings which will be open to all members in good standing of the Ohio State Medical Association. Any member in good standing may have the opportunity to appear before the Committee in behalf of a proposed candidate. In addition, the Committee may request an interview concerning the proposed candidate's qualifications, with the candidate, or with any other member. Each nominee must have a majority vote in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the district for which he is nominated. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates, provided however that only those candidates may be nominated whose names have been filed with the Executive Secretary at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon filing of such candidate name, the Executive Secretary, if such candidate is eligible for election, shall prepare and transmit this information to each member of the House of Delegates. No candidate may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at such meeting. The Executive Secretary shall cause to be published in The Journal in advance of such meeting of the House of Delegates biographical information on all eligible candidates meeting the requirements of filing and transmittal.

(NOTE: Underlining indicates new material)

"The last resolution to be considered by your committee was that on nominating committee procedures and nominations for the office of President-Elect. This resolution was discussed at length by former members of the Nominating Committee, the Ohio State Medical Association staff, members of The Council and interested members. It is the recommendation of the committee that this resolution be amended as follows:

#### AMENDED RESOLUTION NO. 18

Nominating Committee Procedures and Nominations  
For the Office of President-Elect

WHEREAS, At the 1964 Annual Meeting of this Association, the House of Delegates adopted recommendations of the Nominating Committee asking that the Council of the Ohio State Medical Association make a study of the provisions of Chapter 5 of the Bylaws with a view of recommending such changes therein as may be necessary or advisable in order to define clearly the scope, function, and authority of the Committee on Nominations and to prescribe an orderly procedure for the carrying out of the committee's assignments and responsibilities, and

WHEREAS, At the same meeting the House of Delegates adopted Amended Resolution No. 3, directing the President of the Ohio State Medical Association to appoint a committee to study a method or methods of announcing a nominee or nominees for the office of President-Elect prior to the time of the Annual Meeting, and

WHEREAS, The Council and the committee were in-

structed to report their findings at the next Annual Meeting of the Ohio State Medical Association, and

WHEREAS, Both matters were assigned to an Ad Hoc Committee on Revisions of the OSMA Constitution and Bylaws for implementation, and

WHEREAS, Such committee has studied the instructions of the House of Delegates and has developed suggested amendments to carry out the wishes of the House, therefore

BE IT RESOLVED, That the following amended Section 1 of Chapter 5 of the Bylaws of the Ohio State Medical Association be submitted for the consideration of the House of Delegates:

#### CHAPTER 5

##### Nomination and Election of Officers

Section 1. Committee on Nominations. On the first day of the annual meeting the House of Delegates shall elect a Committee on Nominations consisting of one delegate from each councilor district. The chairmanship of the Nominating Committee shall be rotated in numerical order annually among the Councilor district representatives on the committee. The Committee on Nominations shall report to the House of Delegates a ticket containing the name of one or more members for each of the offices to be filled at that annual meeting except that of President-Elect. Prior to selecting a ticket the Committee shall permit the opportunity for hearings which will be open to all members in good standing of the Ohio State Medical Association. Any member in good standing may have the opportunity to appear before the Committee in behalf of a proposed candidate. In addition, the Committee may request an interview concerning the proposed candidate's qualifications, with the candidate, or with any other member. Each nominee must have a majority vote in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the district for which he is nominated.

Section 1(a). Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates, provided however that only those candidates may be nominated whose names have been filed with the Executive Secretary at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect shall be filed with the Executive Secretary of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon filing of such candidate's name, the Executive Secretary, if such candidate is eligible for election, shall prepare and transmit this information to each member of the House of Delegates. No candidate may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at the opening session of such meeting. The Executive Secretary shall cause to be published in The Journal in advance of such meeting of the House of Delegates biographical information on all eligible candidates meeting the requirements of filing and transmittal.

"The committee recommends the adoption of this resolution, as amended, and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Amended Resolution No. 18 be adopted, was approved.

"Mr. President, I would like to move the adoption of the Report of Resolutions Committee No. 2 as a whole."

The House of Delegates approved the motion by official action.

#### Committee Thanked

"It is fitting and proper at this time that I acknowledge the participants and their excellent dis-



cussions that we had in our committee meeting on Monday. The committee meeting was well attended and at times the room was almost filled to overflowing. The discussants came well prepared with considerable informative material to substantiate their points. I wish to extend my sincere and deep appreciation to each member of this committee who served diligently with interest and enthusiasm throughout our entire session. Members of the committee were as follows: Kenneth D. Arn, Montgomery County; Dwight L. Becker, Allen County; William G. Henry, Lucas County; S. A. Burroughs, Ashtabula County; W. A. White, Jr., Stark County; Samuel L. Weir, Carroll County; O. D. Ball, Perry County; Keith R. Brandeberry, Gallia County; James C. McLarnan, Knox County; James T. Stephens, Lorain County; J. Martin Byers, Highland County, Chairman.

### Report of Resolutions Committee No. 3

Dr. Frederick P. Osgood, Lucas County, reported for Resolutions Committee No. 3, of which he was chairman. The report read as follows:

"The Committee on Resolutions No. 3, appointed at the Monday night meeting to consider seven resolutions which were of an immediate nature and accepted by the House of Delegates, received, gratefully, information from a great many members of the House of Delegates and members of the State Association."

#### RESOLUTION NO. 19

##### Maintaining Professional Freedom

(By Dr. Robert N. Smith, Toledo)

"The Committee considered the resolution submitted by the Fourth District Councilor on "Maintaining Professional Freedom."

"This resolution was considered on its individual merits despite some similarity and overlapping with two other resolutions being considered by another committee.

"The original Resolution No. 19 follows:"

WHEREAS, The American Hospital Association and National Blue Cross are presently exerting heavy pressure on the Senate Finance Committee to include certain professional medical services under the hospital care section of H. R. 6675, the Medicare Bill, and

WHEREAS, If such payments are made, hospitals would be collecting moneys for medical services that are provided by physicians and not by hospitals, and

WHEREAS, Private physicians, free of hospital control, can improve patient care by making constructive criticism of hospital programs, facilities and equipment, and

WHEREAS, Physician-employees of hospitals, subject to administrative pressures and decisions, would find their medical judgment subject to review by lay administrators, and

WHEREAS, Forcing these four physician specialties into the category of hospital employees would cause medical students to select a more independent type of practice, resulting in a shortage of physicians in these four specialties and a subsequent deterioration in the quality of patient care;

NOW, THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association officially inform the United States Senate Finance Committee and Ohio's two U. S. Senators of the profession's strong opposition to the inclusion of the professional services of radiologists, pathologists, anesthe-

siologists and physiatrists, or any other medical practitioners, as a part of the hospital service fee under H. R. 6675, and

BE IT FURTHER RESOLVED, That the individual members of the Ohio State Medical Association, recognizing the danger of the precedent that would be set by such inclusion, also make known their opposition to the Senate Finance Committee and Ohio's two U. S. Senators, and

BE IT FURTHER RESOLVED, That the Association assist these specialty groups to preserve their rights to practice their profession as individual and independent physicians.

There were many speakers to this resolution, who made the Committee feel the need for the resolution with some modifications. For this reason the Committee recommends that Resolution No. 19, as submitted, be not adopted and submits a substitute resolution as follows:

#### SUBSTITUTE RESOLUTION NO. 19

##### Maintaining Professional Freedom

WHEREAS, The American Hospital Association and the National Blue Cross plans include in their charges for hospital care fees for professional medical services provided by radiologists, pathologists, anesthesiologists and physiatrists, and

WHEREAS, When such payments are made to hospitals, the hospitals are collecting moneys for medical services that are provided by physicians and not by hospitals, and

WHEREAS, Private physicians, free of hospital control, can improve patient care by making constructive criticism of hospital programs, facilities and equipment, and

WHEREAS, Forcing these four physician specialties into the category of hospital employees may cause medical students to select a more independent type of practice, resulting in a shortage of physicians in these four specialties and a subsequent deterioration in the quality of patient care;

NOW, THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association disapprove of the inclusion of the fees for professional services of radiologists, pathologists, anesthesiologists and physiatrists, or any other doctor of medicine, as a part of the hospital service charges, and

BE IT FURTHER RESOLVED, That the Association assist these specialty groups to preserve their rights to practice their profession as individual and independent physicians.

"Mr. President, I move the adoption of Substitute Resolution No. 19."

By official action, the recommendation of the committee, namely, that Substitute Resolution No. 19 be adopted, was approved.

#### RESOLUTION NO. 20

##### Comprehensive Mental Health Planning

(By Delegate from Clinton County)

WHEREAS, The Interim Report to the Governor from the Citizen's Committee of the Comprehensive Mental Health Planning Project, contains enough urgency in its first report to justify action at this time, and

WHEREAS, Recommendations which the committee indicated as urgent can be delayed only at the risk of deterioration in the care of the mentally ill and retarded in Ohio;

NOW, THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association House of Delegates meeting May 9, 1965, urge action by the Legislature on these matters prior to the adjournment of the 106th legislative session.

"Resolution No. 20 had reference to the present interim report of the Citizen's Committee on Comprehensive Mental Health Planning.

"Evidence which was presented revealed that this

report is still in progress and for this reason the Committee suggests that the House of Delegates refer it to Council for reference to the appropriate committee and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 20 be referred to The Council for reference to the appropriate OSMA Committee, was approved.

#### RESOLUTION NO. 21

Reorganization of Department of Mental Hygiene  
(By Lucas County Delegation)

WHEREAS, The prevention, detection, treatment and aftercare of mental illness and retardation require a comprehensive approach based on long range planning and research, and

WHEREAS, Such programs are dependent upon well trained personnel of many disciplines who are assured of support in their efforts over an extended period of time, and

WHEREAS, Such opportunities attract and retain qualified medical and paramedical personnel, and

WHEREAS, Under existing organization in the State of Ohio many important State Mental Health Programs are influenced by the duration of the State Legislature and the tenure of office of the elected and appointed officials;

NOW, THEREFORE, BE IT RESOLVED, That The Council of the Ohio State Medical Association instruct its appropriate committees to explore with other interested organizations in the State of Ohio:

1. The possibility of establishing a state co-ordinating and planning commission having jurisdiction in the field of mental health and retardation organized in the pattern of the Ohio Board of Regents.

2. The creation of a division within the governmental structure of the State whose sole responsibility would be mental health and retardation.

"The discussion which was held relative to Resolution No. 21 led to the following considered opinion of the Committee. It is a forward and healthy approach to bring order to what has been a difficult and confused situation.

"The Committee recommends the adoption of Resolution No. 21 and Mr. President, I so move."

By official action, the recommendation of the committee, namely, that Resolution No. 21 be adopted, was approved.

#### RESOLUTION NO. 22

Preserving Quality of Patient Care

(Submitted by Mahoning County Delegation)

WHEREAS, The United States has achieved the highest quality of medical care obtainable anywhere, and

WHEREAS, The medical profession strongly believes that no person needing health care should be denied care because of inability to pay for it, and

WHEREAS, The American Medical Association has adopted the principle that any government health care program should provide funds only, and not direct services; and further that administration of such a program should be the responsibility of the state government, and

WHEREAS, The so called "Medicare" legislation violates the aforementioned principles, and would tend to result in a system of inferior medical care, and

WHEREAS, It is the ethical and moral obligation of physicians to take whatever action is necessary to protect their patients from inferior care, and

WHEREAS, No physician, morally, ethically or professionally, can serve the best interests of his patient under any third party program that intrudes into the physician-patient relationship and interferes with medical judgment as to diagnosis and treatment, now

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association urge all physicians in Ohio to maintain their professional principles, to continue to care for their patients as before, but not to participate in any system of medical care that would tend to lead to a deterioration in the quality of that care, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association direct its delegates to the American Medical Association to present to the June 1965 Annual Meeting of that organization, a similar resolution, urging all physicians in the United States not to participate in any system of medical care that would tend to lead to a deterioration in the quality of that care.

"The Committee next heard from a great many members of the audience testimony pertinent to Resolution No. 22. It was very evident to all present that the members of the Ohio State Medical Association were cognizant of the implications of such legislation presently being enacted, as affecting in various ways our practices. It was further observed that the persons who were kind enough to express their views were giving the Committee the benefit of their experience and their sincere beliefs.

"Pursuant to this very free discussion the Committee, in weighing all of the evidence, decided to propose a substitute resolution:"

#### SUBSTITUTE RESOLUTION NO. 22

Preserving Quality of Patient Care

WHEREAS, The medical profession rejects the principle of government subsidization of the medical profession, and

WHEREAS, We believe that subsidization of the sick of any age should be limited to the indigent, and

WHEREAS, The medical profession rejects the use of any action that might be construed as a strike against the sick, and

WHEREAS, It is our intention to continue in the future, as we have in the past, to render all necessary medical care to all people regardless of inability to pay, and

WHEREAS, The United States has achieved the highest quality of medical care obtainable anywhere, and

WHEREAS, The so-called Medicare Bill (H.R. 6675) violates the aforementioned principles and would tend to result in a system of inferior medical care, and

WHEREAS, Sec. 6 of the Code of Ethics of the American Medical Association states that "a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care," and

WHEREAS, The 13th Amendment to the Constitution of the United States protects all citizens against voluntary servitude, and

WHEREAS, A physician cannot morally, ethically or professionally serve the best interest of his patients under any third party program that intrudes into the physician-patient relationship and interferes with medical judgment as to diagnosis and treatment, now

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association emphasize to all physicians that they are free to decline to participate in the system of medical care established by H.R. 6675 or any similar legislation and that they are urged to maintain their professional principles, to continue to care for their patients as before but not to participate in any system of medical care that would lend itself to a deterioration in the quality of that care, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association direct its Delegates to the American Medical Association to present, to the June 1965 Annual Meeting of that organization, a similar resolution urging all physicians in the United States to adopt the same course, and

BE IT FURTHER RESOLVED, The action recommended



by this resolution be publicized in a suitable manner to the entire membership of the Ohio State Medical Association.

"The above substitute resolution is unanimously recommended for adoption and Mr. President, I so move."

By official action of the House of Delegates, the title of Substitute Resolution No. 22 was amended to read "Preserving Freedom and Quality of Medical Care."

By official action, the eighth "Whereas" paragraph of the substitute resolution was deleted. The deleted material reads as follows: "Whereas, The 13th Amendment to the Constitution of the United States protects all citizens against involuntary servitude, and"

A third amendment was officially adopted by the House of Delegates changing the first "Therefore, Be It Resolved" paragraph. After the word "before" the words "even without pay" were inserted.

A substitute for Substitute Resolution No. 22 was submitted by Dr. L. J. McCormack, Cuyahoga County. The substitute resolution for Substitute Resolution No. 22 was defeated by official action of the House of Delegates.

It was duly moved and seconded that Substitute Resolution No. 22 be tabled. A roll call was requested. The request was granted and the roll was called. The motion to table failed by a vote of 78 to 79.

After considerable discussion, by official action of the House of Delegates, Substitute Resolution No. 22, as amended on the floor of the House, was adopted by a vote of 77 to 71. Substitute Resolution No. 22, as amended, reads as follows:

#### AMENDED SUBSTITUTE RESOLUTION NO. 22

##### Preserving Freedom and Quality of Patient Care

WHEREAS, The medical profession rejects the principle of government subsidization of the medical profession, and

WHEREAS, We believe that subsidization of the sick of any age should be limited to the indigent, and

WHEREAS, The medical profession rejects the use of any action that might be construed as a strike against the sick, and

WHEREAS, It is our intention to continue in the future, as we have in the past, to render all necessary medical care to all people regardless of inability to pay, and

WHEREAS, The United States has achieved the highest quality of medical care obtainable anywhere, and

WHEREAS, The so-called Medicare Bill (H.R. 6675) violates the aforementioned principles and would tend to result in a system of inferior medical care, and

WHEREAS, Sec. 6 of the Code of Ethics of the American Medical Association states that "a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care, and

WHEREAS, A physician cannot morally, ethically or professionally serve the best interest of his patients under any third party program that intrudes into the physician-patient relationship and interferes with medical judgment as to diagnosis and treatment, now

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association emphasize to all physicians that they are free to decline to participate in the system of medical care established by H.R. 6675 or any similar legislation and that they are urged to maintain their professional principles, to continue to care for their patients as before even without pay but not to participate in any system of medical care that would lend itself to a deterioration in the quality of that care, and

BE IT FURTHER RESOLVED, That the Ohio State Medical Association direct its Delegates to the American Medical Association to present, to the June 1965 Annual Meeting of that organization, a similar resolution urging all physicians in the United States to adopt the same course, and

BE IT FURTHER RESOLVED, The action recommended



Checks from the AMA-Education and Research Foundation, representing contributions from this State to Ohio's three medical schools were presented before the House of Delegates by President Robert E. Tschanz. From left, are Dr. John L. Caughey, Jr., Western Reserve University School of Medicine; Dr. Tschanz; Dr. Joseph Lindner, Jr., University of Cincinnati College of Medicine; and Dr. Richard L. Meiling, Ohio State University College of Medicine.

by this resolution be publicized in a suitable manner to the entire membership of the Ohio State Medical Association.

**RESOLUTION NO. 23**  
**Change in AMA Health Education Leaflet**

With the permission of the House of Delegates, Resolution No. 23, entitled "Change in AMA Health Education Leaflet," was withdrawn and expunged from the record at the request of the sponsors.

**RESOLUTION NO. 24**  
**To Define Justifiable Abortion**  
**(By a Member of the Cleveland Delegation)**

WHEREAS, The laws of the State of Ohio require that an abortion may be performed only when it is necessary to save the life of the mother, and

WHEREAS, Such restriction may cause unnecessary delay, thus endangering the health or life of the patient, or may condemn the fetus to a lifetime of suffering due to grave physical or mental defects, and

WHEREAS, A clear and acceptable definition of the conditions under which a physician might perform a justifiable abortion would standardize and clarify criteria for reaching a decision to perform an abortion, and

WHEREAS, Such a clear and acceptable definition already exists in paragraph 2 of section 207.11 of the model penal code (1959) drawn by the American Law Institute as follows:

#2 (Justifiable abortion) A licensed physician is justified in terminating a pregnancy if (a) he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defects, or the pregnancy resulted from rape by force or its equivalent as defined in section 207.4\* or from incest as defined in section 207.3.

\*Includes females less than 10 years old and when the female is less than 16 years of age and the male is at least 5 years older with or without the female's consent.

THEREFORE, BE IT RESOLVED, That this Ohio State Medical Association recommend to the Legislature of the State of Ohio that the existing laws relating to abortion be amended by deleting section 2901.16 of the Ohio Revised Code and substituting therefore the following language or its equivalent as a new section:

**"2901.16. Attempt to Procure Abortion.**

No person shall prescribe or administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, except that a Doctor of Medicine or a Doctor of Osteopathy licensed to practice medicine in the State of Ohio may procure such miscarriage if (a) he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defects, or the pregnancy resulted from rape by force or its equivalent\* (defined in section 207.4 of the Model Penal Code, 1959, of the American Law Institute) or from incest (defined in section 207.3, *ibid.*), and (b) that there is concurrence of two or more physicians that the abortion is justified.

Whosoever violates this section, if the woman either miscarries or dies as a consequence thereof, shall be imprisoned not less than one nor more than seven years."

\*Includes females less than 10 years old and females less than 16 years of age when the male is at least 5 years older or without the female's consent.

BE IT FURTHER RESOLVED, That the officers and staff of the Ohio State Medical Association be instructed to bring this resolution to the attention of appropriate Ohio State legislators, the Governor of Ohio, and such other persons as they may wish, and to urge its implementation.

"It was the general consensus that this resolution presents an expression of the present-day attitude of most physicians toward this problem. It should be properly brought, as the resolution states, to the at-

tention of the State Legislature and the Governor for implementation. For this reason, the Committee recommends the adoption of Resolution No. 24 with a minor change, the insertion of the word 'additional' in the final clause of the new section entitled '2901.16 Attempt to Procure Abortion.' This will then read, 'and (b) that there is concurrence of two or more additional physicians that the abortion is justified.'"

**AMENDED RESOLUTION NO. 24**  
**To Define Justifiable Abortion**

WHEREAS, The laws of the State of Ohio require that an abortion may be performed only when it is necessary to save the life of the mother, and

WHEREAS, Such restriction may cause unnecessary delay, thus endangering the health or life of the patient, or may condemn the fetus to a lifetime of suffering due to grave physical or mental defects, and

WHEREAS, A clear and acceptable definition of the conditions under which a physician might perform a justifiable abortion would standardize and clarify criteria for reaching a decision to perform an abortion, and

WHEREAS, Such a clear and acceptable definition already exists in paragraph 2 of section 207.11 of the model penal code (1959) drawn by the American Law Institute as follows:

#2 (Justifiable abortion) A licensed physician is justified in terminating a pregnancy if (a) he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defects, or the pregnancy resulted from rape by force or its equivalent as defined in section 207.4\* or from incest as defined in section 207.3.

\*Includes females less than 10 years old and when the female is less than 16 years of age and the male is at least 5 years older with or without the female's consent.

THEREFORE, BE IT RESOLVED, That this Ohio State Medical Association recommend to the Legislature of the State of Ohio that the existing laws relating to abortion be amended by deleting section 2901.16 of the Ohio Revised Code and substituting therefore the following language or its equivalent as a new section:

**"2901.16 Attempt to Procure Abortion.**

No person shall prescribe or administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, except that a Doctor of Medicine or a Doctor of Osteopathy licensed to practice medicine in the State of Ohio may procure such miscarriage if (a) he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defects, or the pregnancy resulted from rape by force or its equivalent\* (defined in section 207.4 of the Model Penal Code, 1959, of the American Law Institute) or from incest (defined in section 207.3, *ibid.*), and (b) that there is concurrence of two or more additional physicians that the abortion is justified.

Whosoever violates this section, if the woman either miscarries or dies as a consequence thereof, shall be imprisoned not less than one nor more than seven years."

\*Includes females less than 10 years old and females less than 16 years of age when the male is at least 5 years older with or without the female's consent.

BE IT FURTHER RESOLVED, That the officers and staff of the Ohio State Medical Association be instructed to bring this resolution to the attention of appropriate Ohio State legislators, the Governor of Ohio, and such other persons as they may wish, and to urge its implementation.

"Mr. President, I move the adoption of this resolution as amended."

By official action of the House of Delegates, the



recommendation of the committee, namely, that Amended Resolution No. 24 be adopted, was approved.

#### RESOLUTION NO. 25

##### AAPS Essay Contest

BE IT RESOLVED, That the Ohio State Medical Association endorse the Essay Contest of the Association of American Physicians and Surgeons with the two titles, "The Advantages of Private Medical Care" and "The Advantages of the American Free Enterprise System."

"This resolution met with no objection on the part of any of the Committee, and, Mr. President, the Committee recommends the adoption of Resolution No. 25, and for the Committee I so move."

By official action of the House of Delegates, the recommendation of the committee, namely, that Resolution No. 25 be adopted, was approved.

"Mr. President, I move the adoption of the report of Resolutions Committee No. 3 as a whole, as amended."

The House of Delegates approved the motion by official action.

"May I express to you, Mr. President, my gratitude for providing such a dedicated group of men to serve on this emergency committee. Without their help and the very free and helpful advice of those members of the society who spoke to our Committee this report would have been impossible.

"Members of the staff have been extremely helpful in expediting this report, working against time, and we appreciate this. Members of the committee were: Carl A. Minning, Clermont County; Mason Jones, Montgomery County; Walter A. Daniel, Seneca County; L. J. McCormack, Cuyahoga County; Leonard V. Phillips, Summit County; Robert N. Lewis, Belmont County; K. E. Bennett, Washington County; William M. Singleton, Scioto County; Charles W. Pavey, Franklin County; Richard W. Avery, Medina

County; Frederick P. Osgood, Lucas County, Chairman.

#### Committees and OSMA Staff Thanked

By a standing vote the House of Delegates officially thanked the Reference Committees of the House of Delegates and the entire staff of the Ohio State Medical Association for the time and efforts devoted to the work of the House.

#### Inaugural Ceremony

Dr. Tschantz then asked that all newly elected officers, councilors, delegates and alternates come to the front of the room, where they were officially installed into office by Dr. Tschantz.

Dr. Tschantz then presented the official gavel of the Association to Dr. Crawford, the incoming president, and wished him every success for his year in office.

After he took office, Dr. Crawford presented Dr. Tschantz with the official Past-President's button. Dr. Crawford then addressed the House of Delegates. (See page 661 for text of the inaugural address.)

Dr. H. T. Pease, as immediate Past-President, invited Mrs. Tschantz to the rostrum and presented Dr. and Mrs. Tschantz with a silver engraved tray as the Association's token of appreciation for his year's service as President of the Ohio State Medical Association.

#### Committees Named

Dr. Crawford made the following committee appointments which were officially approved by the House of Delegates:

**Committee on Education** — Dr. Thomas E. Rardin, Columbus, reappointed chairman; Dr. Clyde W. Muter, Warren, reappointed for a five-year term, 1965-1970.

**Judicial and Professional Relations Committee** — Dr. Frank F. A. Rawling, Toledo, reappointed



*These are some of the people who attended the House of Delegates sessions, at dinner in the Saturn Room of the Columbus Plaza Hotel. A dinner immediately preceded each session.*

chairman; Dr. Homer A. Anderson, Columbus, appointed for a five-year term, 1965-1970. Dr. David Fishman, Cleveland, for a term of two years, 1965-1967, to fill the unexpired term of Dr. Thomas R. Curran, deceased.

**Committee on Public Relations and Economics** — Dr. Frederick P. Osgood, Toledo, reappointed chairman; Dr. Luther W. High, Millersburg, appointed for a five-year term, 1965-1970.

**Committee on Scientific Work** — Dr. Samuel Saslaw, Columbus, appointed chairman for the ensuing year. Dr. Jack Schreiber, Canfield, appointed for a five-year term, 1965-1970. Dr. Walter J. Zeiter, Cleveland, appointed for a five-year term, 1965-1970.

#### Amendment to OSMA Constitution and Bylaws

By official action of the House of Delegates, it was requested that a resolution be prepared for con-

sideration of the House in 1966, to amend the Constitution and Bylaws of the Ohio State Medical Association to give the Past-Presidents of the Association the privilege of the floor of the House of Delegates without the right to vote.

#### Vote of Thanks

By a standing vote the House of Delegates adopted a unanimous vote of appreciation to the committees and staff of the Academy of Medicine of Columbus, to the Auxiliary, members of the news media, managements of the Columbus hotels and the Veterans Memorial Building, and to all others who contributed to the success of the 1965 Annual Meeting.

Dr. Crawford announced that the 1966 Annual Meeting would be held in Cleveland the week of May 22.

The House of Delegates then adjourned sine die.

Attest: HART F. PAGE,  
*Executive Secretary.*

## ROLL CALL OF HOUSE OF DELEGATES 1965 ANNUAL MEETING

County	Delegate	First Session	Second Session	County	Delegate	First Session	Second Session
<b>FIRST DISTRICT</b>				VAN WERT	Edward E. White	Present	Present
ADAMS	Francis Stevens	Present	Present	WYANDOT	Donald P. Smith	Present	Present
BROWN	John A. Powell	Present	Present	<b>FOURTH DISTRICT</b>			
BUTLER	Paul N. Ivins	Present	Present	DEFIANCE	Charles E. Jaekle	Present	Present
CLERMONT	John H. Varney	Present	Present	FULTON	William J. Neal	Present	Present
CLINTON	Carl A. Minning	Present	Present	HENRY	Edwin C. Winzeler	Present	Present
HAMILTON	Edmond K. Yantes	Present	Present	LUCAS	Edmond F. Glow	Present	Present
	William C. Ahlering	Present	Present		William G. Henry	Present	Present
	Joseph G. Crotty	Present	Present		Frederick P. Osgood	Present	Present
	Joseph E. Ghory	Present	Present		John B. Sawyer	Present	Present
	Ralph S. Grace	Present	Present		Max T. Schnitker	Present	Present
	J. Robert Hudson	Present	Present		Randolph P. Whitehead	Present	Present
	Harry K. Hines	Present	Present	OTTAWA	V. William Wagner	Present	Present
	Daniel V. Jones	Present	Present	PAULDING	D. E. Farling	Present	Present
	Carl W. Koehler	Present	Present	PUTNAM	James B. Overmier	Present	Present
	Clyde S. Roof	Present	Present	SANDUSKY	Robert A. Borden	Present	Present
	Albert D. Weyman	Present	Present	WILLIAMS	Allen G. Jackson	Present	Present
HIGHLAND	R. M. Woolford	Present	Present	WOOD	Paul F. Orr	Present	Present
WARREN	J. Martin Byers	Present	Present				
	Thomas E. Fox	Present	Present				
<b>SECOND DISTRICT</b>				<b>FIFTH DISTRICT</b>			
CHAMPAIGN	Isador Miller	Present	Present	CUYAHOGA	J. C. Avellone	Present	Present
CLARK	David D. Smith	Present	Present		James O. Barr	Present	Present
DARKE	Ernest H. Winterhoff	Present	Present		Joseph L. Bilton	Present	Present
GREENE	Maurice M. Kane	Present	Present		William F. Boukalik	Present	Present
MIAMI	Roger C. Henderson	Present	Present		John H. Budd	Present	Present
MONTGOMERY	Dale A. Hudson	Present	Present		E. P. Coppedge, Jr.	Present	Present
	Kenneth D. Arn	Present	Present		Nicholas G. DePiero	Present	Present
	Robert A. Bruce	Present	Present		Eduard Eichner	Present	Present
	Mason Jones	Present	Present		David Fishman	Present	Present
	William M. Porter	Present	Present		W. E. Forsythe	Present	Present
	J. Richard Strawsburg	Present	Present		John J. Grady	Present	Present
	James G. Tye	Present	Present		Harry A. Haller	Present	Present
PREBLE	C. J. Brian	Present	Present		C. R. Jablonoski	Present	Present
SHELBY	George J. Schroer	Present	Present		F. R. Kelly	Present	Present
<b>THIRD DISTRICT</b>					V. T. LaMaida	Present	Present
ALLEN	Dwight L. Becker	Present	Present		M. H. Lambright	Present	Present
	Fred P. Berlin	Present	Present		Frederick V. Light	Present	Present
AUGLAIZE	Elizabeth Y. Kuffner	Present	Present		L. P. Longley	Present	Present
CRAWFORD	Horace Newhard	Present	Present		L. J. McCormack	Present	Present
HANCOCK	Donald R. Brumley	Present	Present		Paul A. Mielcarek	Present	Present
HARDIN	Clarence L. Johnson	Present	Present		George W. Petznick	Present	Present
LOGAN	Ralph K. Updegraff	Present	Present		J. H. Sanders	Present	Present
MARION	Albert M. Mogg	Present	Present		A. B. Schneider, Jr.	Present	Present
MERCER	George H. McIlroy	Present	Present		F. T. Suppes	Present	Present
SENECA	Walter A. Daniel	Present	Present		Howard P. Taylor	Present	Present
					E. C. Weckesser	Present	Present
				GEAUGA	Simon Ohanessian	Present	Present
				LAKE	Alfred C. Mahan	Present	Present
					G. Robert Smith	Present	Present

(Continued on Next Page)



## House of Delegates Roll Call (Continued)

County	Delegate	First Session	Second Session	County	Delegate	First Session	Second Session
<b>SIXTH DISTRICT</b>				<b>TENTH DISTRICT</b>			
COLUMBIANA	John A. Fraser	Present	Present	DELAWARE	A. R. Callander	Present	Present
MAHONING	L. P. Caccamo	Present	Present	FAYETTE	Robert Heiny	Present	Present
	G. E. DeCicco	Present	Present	FRANKLIN	Homer A. Anderson	Present	Present
	S. F. Gaylord	Present	Present		Drew J. Arnold	Present	Present
	J. V. Newsome	Present	Present		Joseph A. Bonta	Present	Present
PORTAGE	Edward A. Webb	Present	Present		William E. Hunt	Present	Present
STARK	Aubrey R. Furnas, Jr.	Present	Present		John R. Huston	Present	Present
	Maurice F. Lieber	Present	Present		Robert M. Inglis	Present	Present
	J. R. Seesholtz	Present	Present		Charles W. Pavey	Present	Present
	William A. White, Jr.	Present	Present		Allen D. Puppel	Present	Present
SUMMIT	William Dorner, Jr.	Present	Present		D. W. Traphagan	Present	Present
	Thomas W. Jackson	Present	Present	KNOX	James C. McLarnan	Present	Present
	James W. Parks	Present	Present	MADISON	Sol Maggied	Present	Present
	Leonard V. Phillips	Present	Present	MORROW	Joseph P. Ingmire	Present	Present
	James G. Roberts	Present	Present	PICKAWAY	Jasper M. Hedges	Present	Present
	F. J. Waickman	Present	Present	ROSS	Robert E. Swank	Present	Present
TRUMBULL	Raymond Ralston	Present	Present	UNION	E. J. Marsh	Present	Present
<b>SEVENTH DISTRICT</b>				<b>ELEVENTH DISTRICT</b>			
BELMONT	Robert N. Lewis	Present	Present	ASHLAND	Charles H. McMullen	Present	Present
CARROLL	Samuel L. Weir	Present	Present	ERIE	Emil J. Meckstroth	Present	Present
COSHOCTON	N. L. Wright	Present	Present	HOLMES	Adam J. Earney	Present	Present
HARRISON	Elias Freeman	Present	Present	HURON	William R. Graham	Present	Present
JEFFERSON	Carl F. Goll	Present	Present	LORAIN	Max Durfee	Present	Present
MONROE					James T. Stephens	Present	Present
TUSCARAWAS	R. E. Rinderknecht	Present	Present	MEDINA	Richard W. Avery	Present	Present
				RICHLAND	Carroll E. Damron	Present	Present
					Carl M. Quick	Present	Present
				WAYNE	Albert B. Huff	Present	Present
<b>EIGHTH DISTRICT</b>				<b>OFFICERS</b>			
ATHENS	Robert E. Main	Present	Present	President	Robert E. Tschantz	Present	Present
FAIRFIELD	J. L. Kraker	Present	Present	President-Elect	Henry A. Crawford	Present	Present
GUERNSEY	James A. L. Toland	Present	Present	Past-President	Horatio T. Pease	Present	Present
LICKING	J. R. Wells	Present	Present	Treasurer	Philip B. Hardyman	Present	Present
MORGAN	Henry Bachman	Present	Present				
MUSKINGUM	Joseph C. Greene	Present	Present				
NOBLE	Edward G. Ditch	Present	Present				
PERRY	O. D. Ball	Present	Present				
WASHINGTON	Kenneth E. Bennett	Present	Present				
<b>NINTH DISTRICT</b>				<b>COUNCILORS</b>			
GALLIA	Keith R. Brandeberry	Present	Present	District			
HOCKING	Jan S. Matthews	Present	Present	First	Robert E. Howard	Present	Present
	L. W. Starr	Present	Present	Second	Theodore L. Light	Present	Present
JACKSON	Carl J. Greever	Present	Present	Third	Frederick T. Merchant	Present	Present
LAWRENCE	Harry Nenni	Present	Present	Fourth	Robert N. Smith	Present	Present
MEIGS	Roger P. Daniels	Present	Present	Fifth	P. John Robecheck	Present	Present
PIKE	Albert M. Shrader	Present	Present	Sixth	Edwin R. Westbrook	Present	Present
SCIOTO	William Singleton	Present	Present	Seventh	Benjamin C. Diefenbach	Present	Present
VINTON				Eighth	Robert C. Beardsley	Present	Present
				Ninth	George Newton Spears	Present	Present
				Tenth	Richard L. Fulton	Present	Present
				Eleventh	Lawrence C. Meredith	Present	Present
Totals						154	157

### AMA Book on New Drugs Is Now Available

A book that gives physicians much needed information about new drugs is ready for distribution.

Issued by the Council on Drugs of the American Medical Association and titled simply *New Drugs*, it was designed to meet the specific needs of the practicing physician for a source of up-to-date, authoritative, and unbiased information on single entity drugs introduced within the past 10 years. Physicians may buy the 500-page book from the AMA at a cost of \$5.00 per copy.

*New Drugs* is an entirely different book from *New and Nonofficial Drugs*.

New drugs are described in monographs that give the adopted nonproprietary name, chemical or biological identity, actions and uses, limitations, adverse reactions, precautions, dosage and routes of administration, preparations and their available sizes or strengths, known sources of supply together with

the commercial name or names by which the drug is sold in the U. S., year of commercial introduction in the U. S., year of evaluation, and year of the most recent revision of the Council-sponsored monograph.

### Cincinnati Will Edit New Roentgenology Quarterly

*Seminars in Roentgenology* is the name of a new quarterly publication edited by Dr. Benjamin Felson, of Cincinnati, to begin in 1966. According to announced plans, each issue will be devoted to various facets of a single subject in the overall field, dealt with by recognized authorities in an up-to-date and definitive fashion.

While major emphasis will be on diagnostic aspects, topics of especial current interest in radiotherapy may also be appraised as occasion warrants.

Publishers are Grune & Stratton, Inc., 381 Park Avenue South, New York, N. Y. 10016.

# President's Address . . .

Presented May 9 Before the House of Delegates  
Of the OSMA at Its First Session in Columbus

By ROBERT E. TSCHANTZ, M.D., Canton

I WANT to extend to this ruling body of the Ohio State Medical Association, on the occasion of its 130th year, my sincere thanks for the opportunity you afforded me as president of this Association. This truly has been a year that was filled with work, work and more work.

I can only give you a panoramic view of the many activities carried on by your Association. Let me say that, without the complete support of so many of you in this room as well as many other physicians you represent . . . members of The Council . . . AMA Delegates and Alternates, members of the many active committees . . . and the selfless, untiring work of the OSMA office staff and *The Journal* staff, the progress of this Association would grind to a halt.

## Tribute to George H. Saville

One of the low points of the year for me was Scottie Saville's untimely illness which led to his premature retirement as Executive Secretary. Scottie has, by his life's work and service to this Association, exemplified all that is fine in the executive staffs of medical societies. Scottie, along with Chuck Nelson, for 30 years has given of his many talents to help bring the OSMA to the prominent position it holds among state associations. It is one of the high points of the year to have Scottie here looking so hale and hearty. He will continue as special consultant to the OSMA until his retirement in August of this year.

One of the products of Scottie's excellent work was a young, vigorous, and dedicated group of men to take over the work of the executive office. Hart Page, our new executive secretary, and Charles Edgar, our new director of public relations, were thrown into a maelstrom of work and problems, and they have performed nobly. While I refer to them as being "new" in their present positions, I want to point out that Hart has been a staff member for 19 years and Chuck has been with us nine years. This speaks well of the stability of our staff personnel.

Herb Gillen and Mike Traphagan took on many arduous tasks and they, too, have come through with flying colors. Gordon Moore has done such out-

standing work as assistant managing editor of *The Journal* that Council saw fit in March to promote Gordon to executive editor and executive business manager. Gordon has been with *The Journal* for 17 years.

## Committee Members Dedicated

The many committees have hard-working, dedicated members who approach problems and projects with zeal and with interest. To give you some idea of your OSMA in action, here are some of the projects of these committees:

Hospital Relations—Seriously concerned with regional hospital planning, with emphasis on voluntary planning and heavy emphasis on encouraging local physicians to take leadership roles in such planning.

No one can deny that more and more medical care is being hospital centered. Physicians must take an even closer look at the entire hospital picture, including physicians that are now practicing as hospital employees, hospital costs and hospital administration. Certainly this could more easily be accomplished if physicians were members of hospital boards of trustees, as recommended by the AMA.

At a meeting in Columbus for Emergency Room coverage a responsible official of the Hospital Association stated that an attempt would be made in the near future to change the Medical Practice Act so that hospitals could practice medicine.

At a more recent meeting of the AMA on areawide regional planning held in Miami in November, 1964, it was reported that areawide planning councils should serve to regulate physicians and control their income! They recommended that hospitals should be staffed by salaried physicians. One speaker at Miami went so far as to state that physicians were merely technicians working in a building, and, as such, should have no voice in the construction, administration or use of that building. This statement was challenged by the AMA's legal counsel, Mr. Robert B. Throckmorton, but the Chairman of the AMA Committee on Medical Service, Dr. Willard A. Wright, raised no objection. Incidentally, this same Dr. Willard A. Wright will be presented as a



candidate for President-Elect of the AMA against our own Dr. Charles L. Hudson in June 1965.

I do not make a point of this to in any way belittle the importance of hospitals in the modern care of patients — certainly physicians know better than anyone how vital they are. I do feel very strongly, though, that if medicine is to remain a great dynamic force in America it must remain free. As physicians, we cannot be opposed to prior voluntary hospital planning — as physicians we must, however, oppose any portion of a plan that would destroy the free enterprise system and would lead to a deterioration in the quality of medicine.

**Workmen's Compensation** — Currently preparing a suggested fee schedule for the Bureau of Workmen's Compensation so that these fees can be brought up to date.

**Maternal Health** — Continues to turn out an enormous amount of study and information regarding maternal mortality in Ohio.

**Mental Health** — Busily preparing an excellent statewide postgraduate meeting for all Ohio physicians, to be held next fall.

**Rural Health** — This committee has many programs that have been studied and reproduced by a number of other state associations, such as preceptorship, scholarships, and programs for medical students.

### Code of Cooperation

**Public Relations and Economics** — Working with the Ohio State Pharmaceutical Association to develop a code of cooperation between physicians and pharmacists.

**Occupational Health** — Has met with the State Health Director and members of his staff to study Ohio's water and air pollution problems. Ohio appears to be on the verge of doing something about these problems, and I am sure this committee will be in the foreground.

**Education** — This committee, nucleus of our Joint Committee on Family Practice, which also is represented by our Rural Health Committee and by the Ohio Academy of General Practice, has achieved national recognition for its development of programs for encouraging general practice on the undergraduate and graduate levels.

Regarding our Committee on Scientific Work, I would like to congratulate this Committee for its consistent record of high caliber programs for this meeting. Personally and on behalf of this Association, I would like to express my deep appreciation to Dr. Maurice A. Schnitker, who is retiring this year from this Committee. As Chairman, he provided outstanding leadership and dedication. This entire Association is indebted to him.

I also would like to mention our new Committee on Promoting Attendance at our Annual Meeting. It is hoped that this Committee will provide valuable

service in carrying out its mission. I am certain that its members will give unstintingly of their efforts.

These are just some of the many, many activities of our committees.

### Councilors Extremely Busy

Your Councilors have been extremely busy in the past year. The Councilor District Conferences last fall were well attended and were very successful. Because of many issues confronting us, Council was required to meet very frequently.

Councilors and County Society Officers and Chairmen are to be complimented for their immediate response to the emergency Medicare Rally called last February with less than a week's notice.

This was followed in two brief weeks by our regular County Medical Society Officers Conference. Again, the attendance and participation by Councilors and County Society Representatives was enthusiastic.

Your AMA delegates and alternates have been equally busy. It was the Ohio resolution, formulated and passed by Council and forwarded through your AMA delegation, that set the policy for medical care of the aged adopted by the AMA House of Delegates in the special session held last February.

Preceding this special session, your officers attended a special meeting on care of the aged called by the AMA in December and another special meeting in January. Ohio was very successful in presenting to these sessions the policies and recommendations of the physicians of Ohio.

At the special session of the AMA House in February, your AMA delegation and your AMA Board of Trustees member from Ohio, Dr. Charles Hudson, were extremely successful in presenting and having enacted, almost verbatim, a special resolution on this important subject.

### Principles of Patient Care

The resolution spelled out by specific points, including the following: No person should be denied health care because of inability to pay.

- Use of government revenues to finance such care is appropriate only after other sources are inadequate.
- Every level of government — federal, state and local, should assume a responsible share in the financing of such programs.
- The standard of health care provided should be equal in quality to that available for those who can afford to pay.
- Maximum use should be made of voluntary prepayment mechanisms.
- Administration of such programs should be the responsibility of state governments.
- Eligibility requirements should be fair, realistic uncomplicated and practical.

- Any such health care program should provide funds only, and not direct services.
- Funds for such programs should come from general tax revenues and not Social Security taxes.

When it appeared that the discussion of these issues would go on and on, on the floor of the House, Dr. Hudson drew a solid round of spontaneous applause when he took the floor to tell the delegates that these principles were sound, that they were in the best interests of good medical care, that the House should adopt them and then get to the business at hand, and that it was a time for action — not for delay. In this same talk, Dr. Hudson opposed a National Service Plan for all ages.

Many of you probably are aware that the Ohio delegation will present Dr. Hudson's name at the AMA Annual Convention next month for the office of President-Elect of the American Medical Association. We believe we have an excellent candidate for this most important office, and we believe a majority of the delegates will support our candidate. He proved himself worthy of this highest office by his dedicated work as president of our own Ohio State Medical Association and as a member of the AMA Board of Trustees.

While, in offering his name, we bring honor to Dr. Hudson, we are certain that he, as President of the American Medical Association, will dedicate himself to the principles held high by Ohio's physicians and will bring honor to Ohio.

In my inaugural remarks to this House of Delegates, I stated that, if medicine is to survive as we know and revere it today, participation of all members in the affairs of their profession would be needed.

Unfortunately, this has not been fully achieved. However, the educational campaigns conducted to let the American people know medicine's solution for health care of the aged . . . and to alert the people to dangerous legislation, was so fully implemented by the dedicated work of so many individual physicians, and so many of our county medical societies that this program stands out as a high point of positive action by our profession.

### Physicians Met Challenge

It never can be said with truth and honesty that our struggle was carried on only by the AMA headquarters. Never have so many physicians done so much in carrying the truth to the American people. Our program in Ohio was exceptionally active. To the many physicians who dedicated themselves to the campaign, I say here and now that you brought honor to yourselves and to your profession.

Regardless of the outcome, dissemination of the truth never can be felt to be lost. We must forcefully and continually report the truth as frequently as our foes disseminate the "big lie."

In the words of the AMA President, Donovan Ward, "We were wrong when we thought that the simple, straightforward presentation of the truth would overcome the "big lie."

We did our very best in our educational campaigns. I believe the success of our efforts is measured by a survey by Opinion Research, Inc., of Princeton, N. J. This survey, conducted in March of this year, showed that 74 per cent of the American people favored Eldercare over Medicare.

The health of the American people is medicine's most important concern. Medicine's position has been sound and morally right. It is with deep regret that I see the country so dear to my heart embarking on a course that, historically, when it has been tried, always has led to a deterioration in the medical care of the patient. I have a deep and abiding faith in the American doctor to give his very best in the care of his patient. The fact still remains that a physician harassed by unnecessary bureaucracy, regulations and forms on one hand, and unnecessary minor complaints from free-loading malingerers on the other, will be unable to give the best of himself to the truly ill. Carl Schurz put it all so very well when he said, "Anything that is morally wrong cannot be right in practice."

To paraphrase, I say to you, "Any proposed legislation that is morally, medically and economically wrong cannot be right when it becomes law."

### Powerful Opposition

I cannot predict the exact form the medicare bill will have when and if it is passed. There are powerful forces seeking to restore four types of physician services to the King-Anderson portion of the bill . . . psychiatry, pathology, radiology and anesthesiology. These forces are being led by the American Hospital Association. I understand that it is supported by the national Blue Cross.

It also is reported that Blue Cross and Blue Shield will be asked to underwrite the proposed medicare program. There are some who feel that this may be advantageous in that it will remove physicians from direct contact with the Federal government. Let me point out that socialized medicine came to our good neighbors to the north . . . Canada . . . via the Blue Cross - Blue Shield route. The transition went from indemnity to service plan to government telling physicians that they must sign agreements with the plan or lose their right to practice. This was crystal clear in Saskatchewan.

We must never lose sight of the U. S. Supreme Court decision, which emphatically stated "that what government subsidizes, it controls."

In closing, I would like to emphasize two considered observations.

First, I believe that many of our county societies, as well as our Ohio State Medical Association, are



stronger as a direct result of our battles against government encroachment and control.

Second, The future of this office is in good hands. During the past year I have come to know better and to admire Henry "Smoke" Crawford. He, like my immediate predecessor, Horatio Pease, is dedicated to the main purpose of the Ohio State Medical Association as set forth in our Constitution, namely, to



*Dr. Robert E. Tschantz delivers the President's Address before the first session of the House of Delegates.*

promote the art and science of medicine and the protection of public health.

President Crawford will encounter problems remaining from the past year, and he will have new problems. However, he is a man who will never swerve for he strongly believes in facing a problem head-on in a forthright, direct approach.

One of the outstanding problems we all must face is the question of the dues increase. This is a serious question which you delegates must decide at this Annual Meeting.

I can assure you that your Council did not make this recommendation hastily. The recommendation for the \$15 a year increase was made only after long and sincere study, review, evaluation and projection.

Some members who question this increase have said, "What has the Ohio State Medical Association ever done for me?" My first inclination . . . and one which I repress . . . is to ask, "What have you done for the Ohio State Medical Association?"

#### OSMA Serves Members

However, let me recite a few of the things OSMA has done for the individual member. For example, OSMA was successful in stopping a dangerous bill in the present session of the Ohio General Assembly. This bill, if enacted, would have extended the statute

of limitations on malpractice suit from one to two years.

You can readily see the implications of this bill. Despite the fact that it was backed by a group of powerful interests, your OSMA, representing you before the General Assembly, did stop this legislation.

On the day the bill was killed in committee, an executive of a very large insurance company happened to be in the OSMA office. He voluntarily remarked, "The killing of that bill saved your members from an increase in malpractice insurance rates that would have been more than they will be paying under the proposed dues increase."

This is just one of dozens of bills, some good and some bad, in which your OSMA represents your interests . . . and successfully.

I am not going to recite a long list of what OSMA does for its members. I would point, however, to a few examples, such as helping to resolve differences with various state agencies handling health care programs.

Your OSMA maintains effective liaison with the other health groups, and with the various branches of state government to represent your interests.

Your Committee on Workmen's Compensation currently is working out recommendations for a justified increase in the Workmen's Compensation fee schedule . . . an increase that is long overdue. Every specialty organization in Ohio was requested to recommend changes in fees involving that specialty . . . because the OSMA represents all of medicine.

Your Committee on Hospital Relations is working hard to represent medicine's interests in the field of regional hospital planning.

Your Committee on Mental Health is carrying out the same mission in the field of mental health planning.

Your state headquarters will provide you with reliable information on just about everything involving your practice.

With your 1964 membership card, you received a booklet entitled "Services and Activities of the Ohio State Medical Association." This pamphlet devotes four pages to what OSMA does for its members.

I would point out that the OSMA is tied with two other states for having the lowest state dues. I believe we can raise our state dues from approximately 10 cents a day to 14 cents a day. I don't know where any physician could make a better investment.

#### Face Other Problems

We will face other problems, and some of them will be considerable. The 130-year history of our Association shows that we are consistently able to meet our problems successfully.

To Henry Crawford and to the Ohio State Medical

Association, I pledge my continued, whole-hearted support.

It often has been said that the struggle for freedom never is completely won. By the same token, the struggle for freedom is not lost. Let us now renew our dedication and get on with the struggle.

In closing, I would like to share with you the thoughts of an 88-year-old patient of mine as we talked about the present Washington scene. Here is what he said:

"A politician hastens to agree with the majority.

"He insists that their prejudices are patriotism, that their ignorance is wisdom,—not because he loves them but because he loves himself.

"While the Statesman, the real reformer, points out the mistakes of the multitude, laughs at their follies and denounces their cruelties—not because he loves himself but—because he loves and serves the right and wishes to make his country free. With him, defeat is but a spur to further effort. He who refuses to stoop, who walks the highway of right, is the only victor."

### **Flying Physicians Will Meet In Florida, August 22-27**

The eleventh annual meeting of the Flying Physicians Association will be held at the Deauville Hotel, in Miami Beach, Florida, from August 22 through 27, it was announced by Dr. Nevin J. M. Klotz, 162 Main Street, Wadsworth, chairman of the group's Ohio chapter.

Total membership in the national organization now exceeds 1700 persons, of whom 69 are practicing physicians in Ohio.

Membership is open to all licensed physicians who are members of medical societies approved by the board of directors. Physicians who are not actually pilots but who have an interest in aviation may hold associate membership.

A testimonial reception in honor of Dr. Hazelett A. Moore was arranged by the staff of the McCullough-Hyde Memorial Hospital in Oxford, recognizing 50 years of service in the medical profession. He has been in the Oxford community for 45 years. *The Oxford Press* devoted many columns of space to a feature article and editorial praise for Dr. Moore and his service to the community.

\* \* \*

Dr. John Edwin Brown, Sr., was the subject of a feature article in the *Columbus Sunday Dispatch*. The occasion was his 101st birthday. Retired from medical practice, but active in his many fields of interest, Dr. Brown maintains his residence in Columbus and spends winters in Florida.

\* \* \*

Dr. Raymond L. Kercher, gave a health talk to students of the Medina Junior High School.

## **M. D.'s in the News**

Dr. Irvine H. Page, Cleveland, was guest speaker for the annual luncheon meeting of the Akron District Heart Association. His topic was "Living in an Economy of Abundance."

\* \* \*

Dr. Richard L. Jackson spoke before a meeting of the Young Adults Organization in the Trinity Lutheran Church of Willard. His topic, "Every Body Cares," stressed the importance of good health habits.

\* \* \*

Dr. Edward A. Marshall presented the final lecture in the Medical Insight Lecture series sponsored in the Cleveland area by the Huron Road Hospital's Department of Internal Medicine. His topic was "Your Habits and Your Health—Ways To Keep from Dying."

\* \* \*

Dr. Marian Rejent discussed common illnesses of children at a meeting of the Foster Parents of the Child and Family Service of Toledo.

\* \* \*

Dr. David Gillespie, chief of the pulmonary disease service at Cleveland Metropolitan General Hospital, was guest speaker at a Bowling Green program jointly sponsored by the Wood County Academy of General Practice and the Wood County Tuberculosis and Health Association. His subject was emphysema and other respiratory diseases.

\* \* \*

Dr. Fred D. Rohdes, Lima, addressed the Allen County Diabetes League on the topic "The Diabetic and His Doctor."

\* \* \*

Dr. Frank C. Sutton, administrator of the Miami Valley Hospital in Dayton, and consultant for the Hardin Memorial Hospital Company, spoke before a luncheon meeting in Kenton in behalf of the hospital needs survey.

\* \* \*

Dr. Louis Mengoli, chief resident in thoracic surgery at Ohio State University Hospital, Columbus, was guest speaker at a luncheon meeting of the Mt. Gilead Kiwanis Club. The program was arranged by the Morrow County Heart Association.

\* \* \*

Miami University conferred the honorary degree of Doctor of Science upon one of its alumni, Dr. Lloyd E. Larrick, administrator of Christ Hospital, Cincinnati.

\* \* \*

Dr. Royston C. Lewis, Cleveland, spoke on "Factors Concerned in the Development of Coronary Artery Disease," at a meeting of the Willoughby Lions Club.



# Inaugural Address . . .

## Incoming President Views Activities and Goal for Coming Year in Remarks Before House of Delegates

By HENRY A. CRAWFORD, M. D., Cleveland

I WANT TO SERVE NOTICE here and now that I, as President of your Ohio State Medical Association, do not intend to preside over a wake for organized medicine. There have been too many physicians spreading gloom and woe because Medicare has been passed by the U. S. House of Representatives.

There have been few . . . far too few . . . physicians aware of the concrete evidence that medicine's Eldercare campaign prior to the House vote was an outstanding success . . . so successful that it startled and amazed the opponents of medicine's position . . . so successful that it produced an avalanche of public support of our position in a shorter period of time than any other issue within the memory of the most veteran members of the Congress.



*Dr. Henry A. Crawford, newly installed as President of the Association, delivers his Inaugural Address before the final session of the House of Delegates.*

Medicine can be . . . and should be . . . proud of the fact that it accomplished the seemingly impossible in the face of a tremendous majority of mem-

bers of Congress pledged to support bigger government and the so-called "Great Society."

I can tell you that our campaign came so close to defeating the bill on the House floor that . . . No. 1 . . . the floor debate was permitted to go on as long as it did only because backers of this legislation were desperately scrambling for votes, and . . . No. 2 so strong was our campaign that the Democratic Policy Committee and the White House were exerting every conceivable pressure that could be mustered.

### State Campaign

The campaign carried on by the Ohio State Medical Association and a large number of the county medical societies was outstanding.

The American Medical Association and the Ohio State Medical Association will represent as strongly as possible the interests of both patient and physician during the course of the Medicare Bill in the Senate, and other measures before Congress.

Our two educational campaigns have gained for the profession considerable public recognition. In addition, the news media, as a direct result of these campaigns, have developed a much stronger awareness of the profession, of what it represents and what it believes.

As your President, I intend to encourage this awareness and to strengthen the relationship between medicine and the Fourth Estate.

Health care of the aged under Social Security is not our only problem. We are facing other problems in the legislative halls. We are facing problems in other fields of medical interest.

I want to emphasize that we are facing these problems. We are not . . . we must not . . . turn our backs on them. We must apply all the energy, effort and thought at our command to solve these problems. They must be solved in the best interests of our patients.

### Other Government Encroachments

You should be alert to another measure in Congress that poses a direct threat to American medicine. This measure, Senate Bill 512 and H.R. 3140, would establish 32 regional health centers whereby the Fed-

eral Government would provide diagnostic and treatment facilities for heart disease, cancer and stroke.

Your Council has officially gone on record in strong opposition to this dangerous proposal. The Council has pointed out that such services already are available. Government centers will seriously disrupt the medical staffs of existing facilities which now provide the same services. The Federal Government will be competing for doctors to man these centers — and these people are already in short supply. Furthermore, such centers place the Federal Government directly into a medical program of a truly socialized nature.

Another problem is the division of interests of members of the medical profession. I believe we tend to become too involved in our own practice, and in our own specialty. We fail to pay attention to the problems of the medical profession as a whole. We study everything available on prevention and treatment of a coronary — but pay little attention to ways to deliver that service to the patient. Government, closed panels, and labor unions have been quick to fill the void.

### The Voluntary Way

We most certainly are interested in seeing that regional hospital planning is carried out voluntarily on a sound and logical basis.

We must devote our efforts to mental health planning for the same reasons.

We are not ignoring the shortage of family physicians. We study and testify on every bill involving medicine and health in The Ohio General Assembly. Out of 1400 bills, about 200 had medical connotations. We have met with solid success in dealing with most of these measures.

While you are in Columbus, take the time to call on your representatives and senators just to say, "Hello." They appreciate this and they are reminded that you are interested in their deliberations.

I wish also to express my firm belief that the medicare campaign has served to revitalize medicine as an organization, and to produce a more effective voice for the profession on the national, on the state and . . . of most importance . . . on the county medical society level.

I urge you not only to continue your interest, your support and your activities to this end . . . but also to develop a healthy interest in the many programs and projects of your Ohio State Medical Association and your own local societies.

Convened here as a legislative body these past three days, we have devoted a tremendous amount of man hours, of deliberation, discussion, and serious thought to a large number of issues. We have, in this final session, arrived at decisions that involve every member of our profession.

In being elected delegates, you have been placed in positions as chosen leaders and representatives of your respective county societies. I call on you to

return to your county societies and report in detail what we have done here. I ask you to do this in order that your members be better informed, that they be more aware of, and understand the purposes of this convention. Let them know what "organized medicine" is . . . and how effectively it works.

In my mind, I see organized medicine as a tree. The county societies represent the roots . . . the State Association represents the trunk . . . and the AMA represents the branches.

Without nourishment and care, the roots cannot survive. Without the roots, the trunk and the branches perish.

This, gentlemen, vividly signifies the importance of the county medical societies you represent.

The following often has been said, but it cannot too often be repeated. Therefore, I again repeat it. Your state officers, your Council, and your state staff stand ready to assist and to serve you in any way possible. All you have to do is to ask.

## Do You Know? . . .

Dr. A. Carlton Ernstene, head of the Cleveland Clinic's Department of Medicine, was installed as president of the American College of Physicians at that organization's 50th anniversary meeting in Chicago.

\* \* \*

The Toledo Council of Social Agencies presented its community services award to Dr. Frank F. A. Rawling. Dr. Rawling is a former president of the council. He is now a trustee of the state college of medicine in Toledo and president of the Toledo Area Medical College and Education Foundation.

\* \* \*

Dr. Joseph T. Wearn, dean emeritus of Western Reserve's School of Medicine, was awarded the George M. Kober Medal for research in scientific medicine. Presentation was made at the annual meeting of the Association of American Physicians in Atlantic City, N. J.

\* \* \*

Dr. James V. Warren, professor and chairman of the Department of Medicine at Ohio State University College of Medicine, was guest speaker at the Annual Meeting of the South Dakota Medical Association. He spoke twice, using the topics, "How Can We Reduce Mortality in Coronary Heart Disease?" and "New Concepts in the Management of Heart Failure."

\* \* \*

Dr. Lester R. Dragstedt, research professor of surgery at the University of Florida, gave the ninth annual Carl H. Lenhart Memorial Lecture in Cleveland, under joint sponsorship of Western Reserve University School of Medicine and the Cleveland Surgical Society. His subject was peptic ulcer.



# Awards Given to Outstanding Scientific Exhibits

SIX entries in the Scientific and Education Exhibit were judged by a committee as outstanding and their sponsors were presented awards at the 1965 Annual Meeting of the Association. They were among 34 Scientific and Educational Exhibits displayed on the exhibit floor at the Veterans Memorial Building.

Planners of the Annual Meeting have authorized a monetary award as well as a permanent type, mounted metal plaque and certificate. Following are the six awards presented, with the honored exhibits and their sponsors:

**Gold Award in Original Investigation:** The exhibit, "Ulcerative Colitis in Children," sponsored by Drs. William M. Michener, Richard G. Farmer and Charles H. Brown, Cleveland Clinic Foundation, Cleveland.

**Gold Award in Teaching:** The exhibit, "Lymphangiographic Evaluation of Lymphatic Flow and Lymphedema," sponsored by Drs. Edward Buonocore, Jess R. Young, Victor G. deWolfe and Edwin G. Beven, Cleveland Clinic Foundation, Cleveland.

**Silver Award in Original Investigation:** The exhibit, "Lumbar Discography: A Twelve Year Experience," sponsored by Drs. John S. Collis, Jr., W. James Garner and Thomas M. Tank, Cleveland Clinic Foundation, Cleveland.

**Silver Award in Teaching:** The exhibit, "The Diagnosis and Management of Pheochromocytoma," sponsored by Drs. John H. Wulsin and Thomas E. Gaffney, University of Cincinnati College of Medicine, Cincinnati.

**Bronze Award in Original Investigation:** The exhibit, "Delivery Force: Traction and Compression Forces Exerted by Obstetrical Forceps and Their Effect on Fetal Heart Rate," sponsored by Drs. John C. Ullery, N. J. Teteris and Andrew W. Botschner, and Miss Betty A. McDaniels, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus.

**Bronze Award in Teaching:** The exhibit, "Clinicopathologic Spectrum of Cutaneous Lupus Erythematosus," sponsored by Drs. W. A. Hawk, K. H. Burdick, Faye A. Rundell and J. R. Haserick, Cleveland Clinic Foundation, Cleveland.

## The Journal To Publish Series On Outstanding Exhibits

Because of the unusual interest that has been shown in the Scientific and Education Exhibits at recent Annual Meetings, *The Journal* will bring to its readers additional information on the six entries judged to be outstanding in 1965.

In coming issues, *The Journal* will present individual articles with illustrations about the exhibits described on this page. This policy is in keeping with a request of the Committee on Scientific Work, approved by The Council. By this means, *The Journal* will pay tribute, not only to sponsors of selected exhibits, but also to all exhibitors whose work appeared at the 1965 Annual Meeting. Many hours of research and study went into each project, before the art and skill of putting the exhibit together began.

Exhibits present a unique phase of medical education. This series of articles will bring *The Journal's* readers at least the high points of interest in each.

## Deadline Announced for Heart Grant Applications

The American Heart Association is now accepting applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1966, according to the Ohio State Heart Association.

September 15, 1965 is the deadline for submitting applications for Established Investigatorships and Advanced Research Fellowships.

Applications for Grants-in-Aid should be submitted by November 1, 1965. Grants-in-Aid are made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies. Additional information may be obtained from the Ohio State Heart Association, 10 East Town Street, Columbus 43215.

Dr. Salvatore M. Sancetta, Cleveland, has been elected president of the Northeastern Ohio Heart Association.

# Highlights and Sidelights . . .

## Here Are Some of the Events and Happenings That Added to a Successful 1965 OSMA Annual Meeting

HERE is a review of some of the events and functions at the 1965 OSMA Annual Meeting that helped to make this year's program an outstanding success. Efforts have been made to highlight only a few typical happenings to give an overall picture of the entire meetings, with its many scientific sessions, unusual array of exhibits, specialty society meetings, luncheons, alumni reunions, get-togethers, etc. For reference to new officers, Proceedings of the House of Delegates and other official reports, turn to the Table of Contents beginning on the inside front cover. Candid photographs added here and there add a bit of the human touch to these reports.

### The Host Society

Dr. John R. Huston, President of the Academy of Medicine of Columbus and Franklin County, of-

ficially opened the first session of the House of Delegates and welcomed those attending to the 1965 OSMA annual Meeting. The Host Columbus Academy and its Auxiliary did much to make the Annual Meeting a success. Numerous local committees functioned both during the meeting and in preparation for the various sessions.

An outstanding service to physicians, and guests, was operation of the local information booth and emergency call service manned by members of the Academy staff. The booth at the Veterans Memorial Building was open as long as sessions were in progress there, and a similar service was maintained at the Columbus Plaza Hotel, while meetings were held there.

### President's Reception

The casual atmosphere of the President's Reception again proved popular for members and guests, as



*In the receiving line at the President's Reception are Mr. and Mrs. George H. Saville, left, and Dr. and Mrs. Robert E. Tschantz. The Reception was given in honor of Mr. Saville, who retires this year after more than 30 years of service with the Association; and Dr. Tschantz, 1964-1965 OSMA President.*



# Receiving Line at President's Reception



*Shown in the receiving line at the Wednesday evening reception are, President-Elect Lawrence C. Meredith with Mrs. Meredith, left, and Incoming President Henry A. Crawford, with Mrs. Crawford.*



*Receiving members and guests at the President's Reception are Hart F. Page, center, OSMA Executive Secretary, with Mrs. Page; and Dr. H. T. Pease, Immediate Past-President, with Mrs. Pease.*

many attended the social event on Wednesday evening. The beautiful and spacious area comprising the Venus, Mars, Jupiter and Saturn Rooms of the Columbus Plaza, provided an ideal locale, where members and guests enjoyed hors d'oeuvres, danced to the music of Chuck Selby and his Orchestra and had an opportunity to chat with their colleagues and other friends.

Honored at this year's reception were Dr. Robert E. Tschantz, 1964-1965 President of the Association, and Mr. George H. Saville, who retires this year after more than 30 years of service as Assistant Executive Secretary, Director of Public Relations, Executive Secretary and finally Consultant to the Association.

In the receiving line at the Reception were President Tschantz and Mrs. Tschantz, Incoming President Henry A. Crawford and Mrs. Crawford, Past-President H. T. Pease and Mrs. Pease, President-Elect Lawrence C. Meredith and Mrs. Meredith, Mr. Hart F. Page, OSMA's new Executive Secretary, with Mrs. Page, and Mr. and Mrs. Saville.

#### Past-Presidents Honored

The Council held a dinner meeting on Monday evening in the Columbus Plaza Hotel, and honored Past-Presidents of the Association. (See photograph of Past-Presidents on page 641 of this issue.)

President Tschantz presided and welcomed several guests, as well as the ladies who attended with their husbands.

Mr. George H. Saville was honored at The Council dinner for his outstanding service to the Association. Gifts were presented to him and to Mrs. Saville.

#### Committees Appointed

Members of most of the Association's committees are appointed by the President and approved by the House of Delegates or by The Council. These committees for the most part advise The Council on matters in the various medical and related fields. A roster of these committees with names of chairmen and members, together with members of The Council, AMA Delegates and Alternates, is printed, beginning on page 682 of this issue.

#### Out-of-State Guests

A number of distinguished visitors from neighboring states honored the Association by attending the Annual Meeting. Among those in attendance, in addition to out-of-state participants in the scientific program, were the following:

Dr. Richard A. Kern, Philadelphia, Pa., President of the Pennsylvania Medical Society.

Dr. Albert C. Esposito, Huntington, W. Va., President of the West Virginia State Medical Association and Mrs. Esposito.

Dr. James S. Klump, Huntington, W. Va., Past-President of the West Virginia State Medical Association.

Dr. Joe M. Black, Seymour, Indiana, President of

the Indiana State Medical Association, with Mrs. Black.

Dr. Luther R. Leader, Birmingham, Michigan, President-Elect of the Michigan State Medical Society, with Mrs. Leader.

Dr. Harold B. Barton, Corbin, Kentucky, Vice-President of the Kentucky State Medical Association, with Mrs. Barton.

#### Lifetime Memberships

Dr. Herbert M. Platter and Dr. Jonathan Forman were named honorary lifetime members of the Ohio Academy of Medical History at that organization's meeting in Columbus in connection with the Annual Meeting of OSMA. It was the first time such honors had been conferred.

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### Association's Specialty Sections With List of Their Officers

Some time in the near future initial plans will be laid for the 1966 Annual Meeting of the Association to be held in Cleveland, the week of May 22. The Committee on Scientific Work will be aided in arranging the program by the Specialty Sections, whose officers work closely with members of the committee. Most of the following sections met during the 1965 Annual Meeting and selected a chairman and secretary, or in some cases re-elected officers. Names and addresses of the current officers are given here for the benefit of members who may wish to correspond with them.

**Section on Anesthesiology**—Chairman, Nicholas G. DePiero, M.D., 9710 Garfield Blvd., Cleveland 44125; Secretary, Edward Hartenian, M. D., 1236 East Rookwood Drive, Cincinnati 45208.

**Section on Ear, Nose and Throat**—Chairman, Charles E. Kinney, M. D., 10515 Carnegie Ave., Cleveland 44106; Secretary, Stephen Hogg, M. D., 256 Wm. H. Taft Rd., Cincinnati 45219.

**Section on Internal Medicine**—Chairman, William Bradley, M.D., 497 E. Town St., Columbus 43215; Secretary, R. A. Van Ommen, M. D., 2020 E. 93rd St., Cleveland 44106.

**Section on Neurological Surgery**—Chairman, Laurence M. Weinberger, M. D., 157 W. Cedar St., Akron; Secretary, George H. Hoke, M. D., 211 Broadway, Lorain 44051.

**Section on Obstetrics and Gynecology**—Chairman, Lester A. Ballard, Jr., M. D., 2105 Adelbert Rd., 44106.

**Section on Occupational Medicine**—Chairman,

*(Continued on Next Page)*



Lee H. Miller, M. D., Proctor & Gamble Co., Ivorydale Technical Center, Cincinnati 45217; Secretary, W. W. Davis, M. D., North American Aviation, Inc., 4300 E. Fifth Ave., Columbus 43219.

**Section on Ophthalmology** — Chairman, James M. Andrew, M. D., 150 E. Broad St., Columbus 43215; Secretary, Russell J. Nicholl, M. D., 10515 Carnegie Ave., Cleveland 44106.

**Section on Pathology** — Chairman Colin R. Macpherson, M. D., Department of Pathology, OSU College of Medicine, Columbus 43210; Secretary, L. J. McCormack, M. D., 2020 East 93rd St., Cleveland 44106.

**Section on Pediatrics** — Chairman, Chester T. Kasmersky, M. D., 4150 Indianola Ave., Columbus 43214; Secretary, Henry Saunders, M. D., 2002 Warrensville Center Road, Cleveland 44121.

**Section on Physical Medicine** — Chairman, Karl J. Olsen, M. D., 2020 East 93rd St., Cleveland 44106; Secretary, Marvin Spiegle, M. D., Department of Physical Medicine, Ohio State University, Columbus 43210.

**Section on Psychiatry and Neurology** — Chairman W. Donald Ross, M. D., Cincinnati General Hospital, Cincinnati 45229; Secretary, Philip Rond, M. D., Mt. Carmel Hospital, Columbus 43222.

**Section on Radiology** — Chairman, Fred Rose, M. D., University Hospitals, Cleveland; Secretary, Benjamin F. Jackson, Deaconess Hospital, 4229 Pearl Rd., Cleveland 44109.

## Officers of Specialty Societies In Ohio Are Announced

A number of Ohio Specialty Societies cooperated in sponsoring programs in connection with OSMA Annual Meeting, many of them combining their programs with those of the OSMA Specialty Sections. Some of these organizations held business meetings and elected or re-elected officers. Following are the officers announced to *The Journal* before this issue went to press. (In some instances, the officers are the same as those of the OSMA Specialty Sections.)

**Ohio Chapter, American College of Chest Physicians** — President Jane P. McCollough, M. D., 4345 Acadia Drive, Cleveland 44121; Secretary-Treasurer, John L. Friedman, M. D., 210 Wm. Howard Taft Rd., Cincinnati 45219.

**Ohio Society of Ear, Nose and Throat** — President, Charles E. Kinney, M. D., 10515 Carnegie Ave., Cleveland 44106; Secretary, Stephen Hogg, M. D., 256 Wm. Howard Taft Rd., Cincinnati 45219.

**Ohio Society of Internal Medicine** — President, John J. Grady, M. D., 15000 Madison Ave., Cleve-

land 44107; Secretary-Treasurer, Sanford F. Gaylord, 1005 Belmont Ave., Youngstown 44504.

**Ohio Neurosurgical Society** — President, Laurence M. Weinberger, M. D., 157 W. Cedar St., Akron; Secretary, George H. Hoke, M. D., 211 Broadway, Lorain 44051.

**Ohio Ophthalmological Society** — President, Herbert Kesinger, M. D., 740 East Park St., Sandusky 44870; Secretary-Treasurer, Robert H. Magnuson, M. D., 150 E. Broad St., Columbus 43215.

**Ohio Society of Pathologists** — President Colin R. Macpherson, M. D., Department of Pathology, OSU College of Medicine, Columbus 43210; Secretary, L. J. McCormack, M. D., 2020 East 93rd St., Cleveland 44106.

**Ohio Chapter, American Academy of Pediatrics** — President, Thomas E. Shaffer, M. D., 561 So. 17th St., Columbus 43205; Secretary-Treasurer, Lawrence C. Thompson, M. D., 120 Sturges Ave., Mansfield 44903.

**Ohio Society of Physical Medicine and Rehabilitation** — President, Richard D. Burk, M. D., 254 Crosswell Rd., Columbus 43214; Secretary, Ben L. Boynton, M. D., 326 Locust St., Akron 44302.

**Ohio Psychiatric Association** — President, W. Donald Ross, M. D., Cincinnati General Hospital, Cincinnati; Secretary, Philip Rond, M. D., Mt. Carmel Hospital, Columbus 43222.

**Ohio Committee on Trauma, American College of Surgeons** — President, Thomas W. Morgan, M. D., First Ave. and Cedar St., Gallipolis; Secretary-Treasurer, Ray E. Ebert, M. D., 327 E. State St., Columbus 43215.

## The Rehabilitation of Veterans Is Subject of Pamphlet

How the Veterans Administration brings instruction and training into the homes of seriously disabled veterans and helps them to become independent, self-supporting members of their home communities, is related in a new pamphlet.

The pamphlet, "To Work Again — to Live Again, The Vocational Rehabilitation of Homebound Veterans," is for sale by the U. S. Government Printing Office at 45 cents.

Six Cleveland specialists presented the final program in a health education series presented at Mt. Sinai Hospital. Demonstrations and discussions covered a kidney scanning device, a cardiac monitor, light coagulator, microscopic surgery, artificial kidney, etc. Participating were Drs. Bennett Levine, Bernard Charms, Jerome Gans, Irwin Readerman, Erwin Levin and Victor Vertes.

# Annual Meeting Attendance . . .

Here Is a Record of Members and Guests Who Attended  
Columbus Session, with Comparisons for Other Years

**T**ABULATION of records for the 1965 Annual Meeting of the Association in Columbus, May 9-14, shows an excellent attendance both as to number of Association members and the total of those present. Total registration was 3302; with the following breakdown: Members, 1330; guest physicians, 275; medical students, 335; Woman's Auxiliary, nurses, dentists, technicians and miscellaneous guests, 968; scientific and technical exhibitors, 394.

Following are registration figures for members of the Association by counties and a comparison of Annual Meeting attendance figures from 1919 through 1965:

## Registration by Counties, 1965 Annual Meeting, and Membership Data

County	Total Membership		Ann. Meet. Registration
	Dec. 31, 1964	Apr. 30, 1965	
Adams	12	14	1
Allen	123	120	19
Ashland	25	25	5
Ashtabula	59	55	4
Athens	30	36	7
Auglaize	19	16	4
Belmont	54	55	8
Brown	15	15	—
Butler	170	163	21
Carroll	10	10	3
Champaign	17	17	3
Clark	124	127	17
Clermont	27	28	4
Clinton	23	22	8
Columbiana	71	61	7
Coshocton	24	25	7
Crawford	38	39	9
Cuyahoga	2303	2198	127
Darke	23	23	5
Defiance	22	21	2
Delaware	26	27	8
Erie	65	65	8
Fairfield	52	53	25
Fayette	16	16	6
Franklin	893	837	343
Fulton	19	14	1
Gallia	32	31	5
Geauga	24	24	3
Greene	49	48	10
Guernsey	31	29	6
Hamilton	1225	1186	90
Hancock	45	47	5
Hardin	27	26	4
Harrison	8	7	2
Henry	16	15	2
Highland	19	18	5
Hocking	9	9	4
Holmes	10	10	4
Huron	27	28	7
Jackson	16	16	6
Jefferson	62	54	9
Knox	35	36	13
Lake	107	106	7
Lawrence	106	77	3
Licking	69	67	18
Logan	18	17	3
Lorain	192	189	18
Lucas	616	571	46
Madison	14	12	4
Mahoning	338	330	22
Marion	65	59	14
Medina	52	53	9
Meigs	7	6	1
Mercer	23	21	2
Miami	60	62	15
Monroe	3	2	—
Montgomery	542	520	83
Morgan	3	2	2
Morrow	8	8	3
Muskingum	74	73	19
Noble	3	2	2

County	Total Membership		Ann. Meet. Registration
	Dec. 31, 1964	Apr. 30, 1965	
Ottawa	22	23	2
Paulding	8	7	1
Perry	10	10	3
Pickaway	16	17	6
Pike	12	11	2
Portage	55	55	8
Preble	11	11	2
Putnam	13	12	2
Richland	116	118	21
Ross	41	39	17
Sandusky	46	44	6
Scioto	70	68	15
Seneca	48	41	11
Shelby	23	22	7
Stark	359	344	29
Summit	573	556	36
Trumbull	126	129	7
Tuscarawas	54	50	14
Union	17	18	10
Van Wert	21	20	6
Vinton	2	1	1
Warren	18	16	2
Washington	30	29	7
Wayne	62	59	8
Williams	17	18	4
Wood	41	41	3
Wyandot	11	11	2
Total	9933	9558	1330

## ANNUAL MEETING REGISTRATION FOR 1919-1965 INCLUSIVE

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux. ; Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1813
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with A.M.A.						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			441	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	184	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3436
1965	Columbus	1330	275	335	968	394	3302



# Auxiliary Report for the Year . . .

Presented by the Auxiliary's President Before The  
OSMA House of Delegates at Annual Meeting

By MRS. JOHN D. DICKIE, Toledo

THERE is an old Chinese proverb that goes "You can't clap with one hand." How true when you translate this into the combined efforts of the Auxiliary and the Medical Society. In all auxiliary projects, the guiding hand of the Ohio State Medical Association is in evidence.



*Mrs. John Dickie, Toledo, President of the Woman's Auxiliary to OSMA, is shown as she presented the annual report of the Auxiliary before the House of Delegates.*

It is with great pride that I present to you the report of the Woman's Auxiliary to the Ohio State Medical Association for the year 1964-1965.

The past 12 months have been a part of my life I shall never forget, and though each president hopes to fulfill all of the hopes and dreams for his or her organization, we know this is almost never accomplished. I will say, for myself however, I have received much more than I have given during my term as President.

Using the theme "Evaluate the Quality of Your Work," I have endeavored to impress upon our Auxiliaries the value of doing one project well rather than a great deal poorly. The past year has proved that for many Auxiliaries this has been the answer to a successful year.

## Challenging Programs

Of 56 counties paying dues this year, nearly every one has carried on a challenging program. I am sorry to say that we have lost three counties during the past two years — Jackson, Madison, and Portage — while adding one new, enthusiastic and growing group in Clermont County.

I am sure if the County Medical Society in each unorganized county would invite the wives to carry out just one community project, the image of the doctor and his wife in the community would change greatly. I know this is true in many counties because I have witnessed, firsthand, this phenomenon, I believe that if we reinforce one another, we will be inspired in many directions. The time is now for each of you to insist that your wife become interested in the Auxiliary.

Why not give credit to the Woman's Auxiliary for the time and effort many of your wives donate to community projects anyway? Go home and ask your wives to form an Auxiliary where there is none; I know you will not be sorry for doing so.

I know that one of the most important ingredients in a recipe for speechmaking is plenty of shortening. Nevertheless, I feel it is important to give you a thumbnail sketch of our work during the past year.

Without exception, every Auxiliary participated in a vigorous Legislative program. Kaffeeklatsches, writing letters and distributing literature were tops on the list; but in one county, Auxiliary members stood on the steps of their local hospitals during visiting hours and passed out literature. Several Auxiliaries held joint meetings with the Bar and Dental Auxiliaries to discuss Medicare and Eldercare.

One Auxiliary placed posters throughout the county to advertise an open forum on Medicare vs. Eldercare. Members in many counties personally placed literature in all of the waiting rooms of their

doctors. One county Auxiliary president was instrumental in setting up time for discussion of Medicare on the radio show "Peoples Opinion." Questions were phoned in and answers given by local M.D.'s. This is only a sample of work that was done in this field.

### Some Local Projects

Under Community Service, the varied programs proved again that the doctor's wife can contribute much under the name "Woman's Auxiliary." Several Auxiliaries sponsor Golden Age and Senior Citizen Clubs, providing transportation and refreshments for events.

Two Auxiliaries provided and manned book carts in local hospitals. One hundred members of one Auxiliary assisted the T. B. Society in its test program. One Auxiliary conducts a hearing test for school children — 14 members tested 1400 children. Another helps with both hearing and sight tests. Nearly every Auxiliary sponsors a "Future Nurse" Club or holds teas for high school students interested in all health careers. Panels are set up with representatives from various allied medical fields.

During the past year, \$11,822.00 was given for scholarships in nursing, practical nursing, and allied fields, and \$10,945.53 was provided in loans. One Auxiliary helps to sponsor an expectant parents class and has now begun an Adoptive Parents class. One county helps with the meals on wheels project in the local community. One Auxiliary with 70 members had 32 of its members take a first aid course and in turn an Auxiliary group now teaches this course for the American Red Cross. One Auxiliary plays an active part in the daily care of children with cerebral palsy. Several Auxiliaries sponsor baby sitter and teenage programs as well as well-child clinics, block plans for child safety programs and other safety projects such as assisting with follow-up calls in the local poison centers.

Under International Health, a comparatively new project, more than half of the Auxiliaries collected drugs, instruments, and equipment for World Medical Relief in Detroit. Medicines totaling 313 cartons have been delivered. In several Auxiliaries "get acquainted" parties have been held for wives of foreign doctors. This has met with great enthusiasm.

### AMA-ERF Program

The AMA-ERF program continues to be the number one project in Ohio. So far this year, over \$32,974.52 has been contributed by the Auxiliary. Varied and ingenious projects accounted for the remarkable sum. We hope to give California a run for the first place award again this year.

I personally have served on Governor Rhodes' Citizens Committee for Comprehensive Mental Health Planning this past year and a half and am proud to have been a part of this extensive program. This field, I am sure, will be one that will find our Aux-

iliaries busier than ever in service to the community. Scores of members are working in this area already.

Now don't you agree that your wives are pretty terrific in their respective communities? Gone are the days when the doctor's wife keeps her nose out of community affairs, and gone too should be our husband's attitude that we remain home and let someone else do the job.

I wish to thank Dr. Tschantz, Mr. Page, Mr. Edgar, Mr. Moore, Mr. Traphagen, and Mr. Gillen for their help and guidance during the past year. To our advisors, Dr. Diefenbach, chairman, and Drs. Beardsley and Light, my sincere thanks for your willing help. To Mr. Saville our gratitude for his assistance whenever asked.

In closing, I would like to leave you with this thought: We have a unique organization — you and I — one primary standard for belonging. For the men, you have your M.D. degree attached to your names; for the women, we are the wives or widows of M.D.'s. None of us belongs for the purely social benefits derived. Our purpose is to further the cause of medicine and work toward the creation of a better image in our respective communities. Are you doing your part?

I hope my dear husband will agree with what Abby has to say: It takes a man to make a pretty good living, but it takes a woman to make the living pretty good. My Graduation Day is here; I am about to celebrate my homecoming. Thank you one and all for your kind attention.

### Physician Is Named To Direct Cleveland Health Museum

John J. Beeston, M.D., D. P. H., becomes Director of the Cleveland Health Museum on July 1. The announcement was made by Robert M. Stecher, M.D., chairman of the Board of Trustees of the Museum. He fills the vacancy created by Bruno Gebhard, M.D., who several weeks ago announced his retirement after 25 years of service to the Museum as its first and only director.

Dr. Beeston has been a member of the faculty at the University of California, Los Angeles, since 1947. He has been associate professor in both the School of Medicine and the School of Public Health. Since 1962, he also held an office as director of the Academic Communications Facility at UCLA. In this position, he has been responsible for the development and use of audio-visual media including educational television for the campus. For ten years prior to 1962 he was head of the Division of Health Education in the Center for Health Sciences.

Dr. Beeston received his education in England, having been a native of that country. He got his M.D. in 1942 from London University, and his D. P. H. in 1946 from the Royal Institute of Public Health and Hygiene.



# Dr. Hudson Named President-Elect of American Medical Association

HIGH honors came to Ohio when Dr. Charles L. Hudson, Cleveland physician, was named President-Elect of the American Medical Association at the Annual Convention held in New York City, June 20-27. He will be installed as President at the 1966 Annual Convention to be held in Chicago, succeeding at that time Dr. James Z. Appel, of Lancaster, Pennsylvania.

The highest honor that the medical profession can confer on a member—that of Presidency of the AMA—climaxes a distinguished career for Dr. Hudson as a practicing physician, research advocate, medical educator, and as a worker of long standing in the field of organized medicine.

A member of the Board of Trustees of the AMA since 1961, Dr. Hudson also holds a number of responsible offices and appointments on the national level. He has traveled extensively as a member of the AMA Speakers' Bureau; since last year he has been a Delegate to the World Medical Association, representing the U. S. Chapter of that organization; he is now serving as chairman of the AMA Task Force on Animal Care, and is a member of the AMA Committee on Socio-Economic Activities. Another responsibility is that as Vice-President of the AMA Education and Research Foundation Board of Directors.

Other AMA Councils, Commissions and Committees on which he holds appointments include the following: Reference Committee on Insurance and Medical Service (chairman); Committee on Medical Facilities; Committee on Nursing (chairman); Committee on Medical Care for Industrial Workers; Committee on Rehabilitation; Special Study Committee on Medical Education; Commission on the Cost of Medical Care; Subcommittee on the Economics of Medical Care (chairman); Council on Medical Service; Committee on Scientific Activities of the Board of Trustees (chairman); and the Committee to Study World Medical Association (chairman).

## OSMA Past-President

In 1954, Dr. Hudson was named President-Elect of the Ohio State Medical Association and served as President in 1955 and 1956. He had previously served on The Council as Councilor of the Fifth District. In 1956 he began serving as AMA delegate. For several years he served as chairman of the important OSMA Committee on Government Medical Services.

A Past-President of the Academy of Medicine of Cleveland and Cuyahoga County, and a former mem-

ber of the Board of Directors, he has held numerous positions of responsibility in county organization.

In the Academic field, he is Associate Clinical Professor of Medicine at Western Reserve University School of Medicine, and Associate Professor of Medicine at the Cleveland Clinic Educational Foundation.



Robert L. Hudson, M. D.

Honors began coming to Dr. Hudson early in life. He graduated from the Alma College, Alma, Michigan, Magna Cum Laude in 1924. He graduated Cum Laude from the University of Michigan Medical School in 1930.

## Other AMA Reports

Watch for the August issue of *The Journal* and more complete reports on AMA activities in the New York Convention. Reports will include a summary of actions taken by the House of Delegates, other honors conferred on Ohioans, and a report on Ohioans who took part in business proceedings, in the scientific program and in the exhibits.

# Auxiliary Annual Meeting Report . . .

## Auxiliary Convenes in Columbus in Conjunction with OSMA Annual Meeting; Sessions in Christopher Inn

By MRS. S. L. MELTZER, Portsmouth  
Chairman, Publicity Committee

A long and satisfied look backward —  
a dedicated and hopeful look forward . . .

THAT, in a sense, could describe the twenty-fifth anniversary meeting of the Woman's Auxiliary to the Ohio State Medical Association held in Columbus May 12 and 13 at the Christopher Inn. "One of them" was there — one who had served on that first State Board back in 1940 — the world traveller, Mrs. C. W. Kirkland, of Bellaire, a past state president, still enthusiastic, still active. (This probably doesn't "belong," but your reporter can't help noting that it was also twenty-five years ago that nylon hosiery made its debut and certain brands of coffee could be purchased for 13 cents a pound and a rib roast was 23 cents a pound and Don Ameche and Deanna Durbin were the big box office attractions).

Approximately 300 women registered for the 1965 meeting. Mrs. Harold Humphrey, Franklin County, served as Convention chairman and Mrs. Joseph Tomashefski as co-chairman. Mrs. John D. Dickie, Lucas County, presided as President. Mrs. Karl F. Ritter, Allen County, pinch-hit as parliamentarian the first day of Convention. Mrs. A. Paul Hancuff, Lucas County, was present on the second day to serve in that capacity.

The first session on Wednesday morning, May 12, began with the invocation by the Rev. Keith Conning, of Brookwood Presbyterian Church, Columbus, followed by the House of Delegates' pledge of allegiance and pledge of loyalty as led by Mrs. James N. Wychgel, Cuyahoga County.

A cordial note of welcome was extended by Mrs. James H. McCreary, president, Franklin County Auxiliary, to which Mrs. Joseph Moran, Jr., president, Lucas County, was privileged to give the response.

Mrs. Norris E. Lenahan, Tenth District director, introduced the out-of-town guests: Mrs. John Martin, president, and Mrs. Robert Salisbury, president-elect, Kentucky Auxiliary; Mrs. Milton Reed, president, and Mrs. Henry Scovill, first vice-president, Michigan

Auxiliary; Mrs. George A. Curry, president, and Mrs. Wesley Smith, president-elect, West Virginia Auxiliary; Mrs. Bruce Martin, president, Cabell County, West Virginia Auxiliary; Mrs. A. Wesley Hildreth, president, and Mrs. Lucian J. Fronduti, president-elect, Pennsylvania Auxiliary. Mrs. Henry A. Crawford, wife of the incoming OSMA President, was also introduced.

Mrs. Dickie then presented her convention chairman and co-chairman. The two women at the helm of the 1965 annual meeting were warmly received by the delegates. Several pertinent announcements and adoption of the Rules of Convention preceded the report on Roll Call.

It was moved and seconded that the minutes of the 1964 convention not be read since they had already been published in the *Auxiliary News*. Motion was approved. Mrs. Carl F. Goll, Jefferson County, submitted her treasurer's report. The motion to accept that report as audited was approved. First reading of the report of the Resolutions Committee was presented by Mrs. Robert G. Thomas, Lorain County. The Resolution from the Board of Directors made in appreciation and gratitude by the Woman's Auxiliary to the Ohio State Medical Association was given signal action. It was moved and seconded that the second reading of this Resolution be dispensed with and the vote taken so that said Resolution might be given to Dr. Robert T. Tschantz, OSMA President, at the Doctors' Day luncheon. Motion carried.

### President Reports

With Mrs. James Wychgel, first vice-president, in the chair, Mrs. Dickie reported her year's stewardship to the House of Delegates and expressed her warm appreciation for the support she had been given throughout the Auxiliary year. "It is important to set up targets at which to shoot," she reminded the delegates, adding that "we can do small things in a great way, even if we can't all do great things."

Mrs. Dickie, who has travelled some 6,000 miles this past year, announced an all-time high for the state membership: 5,586. She revealed that 44 coun-



ties had worked on project Eldercare, that \$11,822 was given toward nursing scholarships, that there are 56 County Auxiliaries paying dues and that there is marked interest in the proposed workbook for county presidents and presidents-elect. She made mention of the State's newest auxiliary, Clermont County, and announced regretfully that three counties had disbanded: Jackson, Madison and Portage. Her closing words were significant: "You must have long range goals to compensate for short range failures."

On the agenda under new business came the report of the Nominating Committee by its chairman, Mrs. Calvin F. Warner, Hamilton County. Following this report, the president asked for nominations from the floor for each office on the first nominative slate for officers, district directors and directors-at-large. Since there were no nominations from the floor, the President declared the nominative slate the elected slate.

### Nominations

The President then asked for nominations from the floor for members of the 1965-66 Nominating Committee: From the Board, four to be nominated, two elected; from the membership, ten to be nominated, five elected. There being no nominations from the floor, it was moved and seconded that nominations as presented by the Nominating Committee be closed, subject to election in the afternoon—from 4:30 to 5:30 p.m. in Suite E. Motion carried.

Twenty-six names were placed in nomination from the floor for delegates and alternates to the National Auxiliary Convention in New York, June 20-24. Instructions for voting on these nominations that afternoon were detailed by Mrs. Karl F. Ritter, acting parliamentarian. It was moved and seconded that the chairman of delegates be empowered to move any alternate to delegate if necessary and that the president be empowered to appoint any member in good standing who is present in New York as an alternate. Motion approved.

A gracious and moving In Memoriam service by Mrs. George T. Harding, III, Franklin County, concluded the morning's business session.

### Doctors' Day Luncheon

At noon, the traditional Doctors' Day luncheon honored these special guests: Dr. Robert T. Tschantz, president, OSMA, and Mrs. Tschantz; Dr. Henry A.

Crawford, president-elect, OSMA, and Mrs. Crawford; Mrs. William H. Evans, president, National Woman's Auxiliary, and Dr. Evans; the past Ohio Auxiliary presidents; the Auxiliary's Advisory Committee: Dr. Benjamin C. Diefenbach, chairman, Dr. Robert C. Beardsley, Dr. Theodore L. Light, and their wives; Mr. George H. Saville, consultant, OSMA, and Mrs. Saville; Mr. Hart F. Page, executive secretary, OSMA, and Mrs. Page; Mr. Charles Edgar, OSMA Director of Public Relations, and Mrs. Edgar; Mrs. John D. Dickie, president, Ohio Auxiliary, and Dr. Dickie; Mrs. Herbert Van Epps, president-elect, Ohio Auxiliary, and Dr. Van Epps; and out-of-state representatives.

The Lucas County Auxiliary was hostess for the luncheon. Attractive topiary trees centered the tables in square glass containers, each side of which bore a map of Ohio. Msgr. William Kappes of Columbus gave the invocation. A dynamic talk, "What Has Happened to America and Medicine?" was delivered by a woman physician from Gloucester, Massachusetts, whose slight, disarming appearance belied her forcefulness and the ability to capture an audience. Dr. Ever Curtis, the speaker, is the mother of five children, a practicing physician, and counselor for the Massachusetts Medical Society.

### Socialism Counterpart

Dr. Curtis discussed socialism—the Fabian Socialism of England and its American counterpart.

Dr. Curtis' powerful talk brought the audience to its feet at the finish in a tribute to the manner in which this woman physician had presented the serious problem of Medicare, and as an expression of its unanimous and enthusiastic approval of what she had said.

The closing portion of the Doctors' Day luncheon was devoted to the reading of the resolution of gratitude from the Woman's Auxiliary to the Ohio State Medical Association for the support and understanding the doctors have consistently given it for 25 years. Mrs. Dickie, president, was the recipient of a beautiful silver tray from the president of the Lucas County Medical Society, Dr. Philip Whitehead, who congratulated her on a job well done. A significant touch that rounded out the luncheon program was the announcement by Mrs. Dickie that Mrs. William H. Evans, national president from our

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## THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

*President:* Mrs. Herbert F. Van Epps  
425 E. 15th St., Dover 44622

*Vice-Presidents:* 1. Mrs. A. L. Kefauver  
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2. Mrs. M. W. Sloan, II  
415 Towerview Rd., Dayton 45429  
3. Mrs. Edward L. Doerman  
3605 Laskey Rd., Toledo 43623

*Past-President and Nominating Chairman:*  
Mrs. John D. Dickie  
2146 Shenandoah Rd., Toledo 43607

*President-Elect:* Mrs. James Wychgel  
3320 Dorchester Rd., Cleveland 44120

*Recording Secretary:* Mrs. J. W. Loney  
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*Corresponding Secretary:* Mrs. C. Raymond Crawley  
1507 Seven Mile Dr.,  
New Philadelphia 44663

*Treasurer:* Mrs. R. L. Wiessinger  
2280 W. Wayne St., Lima 45805

State of Ohio, had been voted an honorary membership in the Woman's Auxiliary to the Ohio State Medical Association.

### Wednesday Afternoon

The House of Delegates reconvened on Wednesday afternoon for one of the most interesting and helpful portions of convention: The pithy, informative annual reports presented by the respective county presidents. But before the reports were given, Mrs. E. Benjamin Gillette, Lucas County, historian and a former past state president, presented something of a bird's-eye view of the Ohio Auxiliary's past 25 years. It proved quite an imposing view. The county presidents' reports that followed continued to highlight the wealth of activity, enthusiasm, day-by-day participation in the many important Auxiliary projects. These reports spelled out clearly the dedication to the medical profession that underlies every Auxiliary project in which the doctors' wives engage.

The final business to be enacted that first afternoon was the voting on the 1965-66 Nominating Committee and the 26 delegates and alternates to the national convention.

### Thursday Session

On Thursday morning, May 13, the second business session was called to order with Mrs. Dickie, president, presiding. It was moved and seconded that the minutes of the previous day's meeting be omitted, since such minutes will be published in the *Auxiliary News*. Motion approved. There were reports of the Roll Call chairman and the convention chairman and co-chairman. There was a second reading of the report of the Resolutions Committee by its chairman, Mrs. Thomas, but this reading was interrupted in order to permit Mrs. Dickie to ask and receive permission to change the order of business in order to introduce the new president of OSMA, Dr. Henry A. Crawford. In his brief message, Dr. Crawford urged the Auxiliary to help in building up the image of the doctor through community service, to continue to emphasize legislation and to keep up the

battle against Medicare. "We couldn't get along without you," he told the House of Delegates.

The business session then picked up the report of the Resolutions Committee. Action on these resolutions were:

Resolution concerning recommendation of Mrs. C. A. Colombi for National elective office. Motion carried.

Resolution concerning automobile insurance. Motion carried with some dissenting vote.

Resolution concerning the movement of handicapped persons in and around public buildings. Motion carried with some dissenting vote.

Resolution concerning the tetanus immunization campaign. Motion carried with some dissenting vote.

Resolution concerning strengthening of nursing home supervision. Motion carried with dissenting vote.

Resolution concerning the Kerr-Mills Bill and Eldercare: Discussion was held on this resolution. It was moved that resolution be amended to include sending this resolution to all members of the Senate Finance Committee. Latter motion carried. Subsequent motion on the amended resolution carried unanimously.

Resolution concerning the many courtesies received during this Twenty-Fifth Annual Meeting. Motion carried.

Mrs. Calvin Warner, Hamilton County, Finance Committee chairman, presented her report. She moved that the budget as prepared for the committee and as approved by the Board for presentation be accepted for 1965-66. Motion was seconded and carried.

### Awards Presented

For the county auxiliaries, the "big" moment of convention was the presentation of Awards by Mrs. C. H. Bell, Richland County, Credits and Awards chairman. She announced that 51 of 56 counties had submitted the required reports and that 44 had received recognition. Counties receiving Certificates of

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Achievement for fulfilling requirements and meeting deadlines were: In the 1 to 17 membership group: Lawrence, Clermont, Union and Mercer counties; 18 to 30: Ottawa, Huron, Knox, Logan, Geauga, Delaware, Coshocton, Washington and Hardin counties; 31 to 50: Jefferson, Greene, Sandusky, Crawford, Fairfield, Medina, Belmont, Tuscarawas and Hancock counties; 51 to 75: Columbiana, Erie, Marion, Miami, Lake, Licking, Muskingum and Scioto counties; 76 to 150: Richland, Allen, Clark, Trumbull, Butler and Lorain counties; 151-300: Stark and Mahoning counties; 300 and up: Cuyahoga, Franklin, Hamilton, Lucas, Montgomery and Summit counties.

Another high spot was the presentation of awards for AMA-ERF by Mrs. C. R. Crawley, Tuscarawas County, AMA-ERF chairman: Greatest percentage increase over last year: Crawford County, 543%; highest per capita: Tuscarawas County, \$52.70; highest amount contributed: Summit County, \$5,000. Mrs. Crawley announced that as of date of convention, the Ohio Auxiliary contributions have totalled \$34,620.48. Mrs. Chester Young, national chairman of AMA-ERF, was introduced to the House of Delegates and addressed the group briefly.

#### National President Speaks

Mrs. Dickie asked Mrs. Calvin Warner to introduce Mrs. William H. Evans, Mahoning County, president of the Woman's Auxiliary to the American Medical Association. The House of Delegates accorded Mrs. Evans a standing ovation.

"Where Have We Been — Where Are We Going?" was the theme of the national President's talk to the Ohio delegation. She discussed her "Better Health, Better World" concept of her Auxiliary year. She discussed further the top priority program — AMA-ERF. She presented the new and growing kind of joint membership program whereby there is an automatic and simultaneous "joining up" of the husband in his medical society and the wife in its component auxiliary, with the dues for both being paid annually by the husband.

Mrs. Evans declared that "legislatively and politically, we must become more interested." Other pertinent remarks included: "Never forget that you are a doctor's wife and a reflection of your husband . . . don't lose your Auxiliary identity . . . let the community know what the doctors' wives are doing . . . speak up for medicine, but first be sure you have accurate information."

The report of the Election and Tellers Committee revealed these results of the previous day's voting for members of the 1965-66 Nominating Committee and delegates and alternates to the National Convention in New York City. Elected to the Nominating Committee: From the Board — Mrs. John D. Dickie, Mrs. C. F. Goll; from the Membership: Mrs. H. W. Allison, Mrs. B. C. Diefenbach, Mrs. James H.

McCreary, Mrs. Roy Rounds and Mrs. Burdett Wylie. The twenty-six members whose names were given in nomination as delegates and alternates to New York were duly checked.

The installation of new officers for the coming year was conducted by Mrs. Evans, National President, in a brief and meaningful ceremony. Mrs. Evans gave out her own special prescription for getting a job done successfully: "I call it the three d's — devotion, dedication and darn hard work!" Mrs. Hancuff presented the retiring President with the Past-President's pin and welcomed her to the ranks of those dedicated women who have served in such capacity. The outgoing President, Mrs. Dickie, was presented with a gift, the gesture of her proud Lucas County Auxiliary. Mrs. Dickie subsequently bestowed the president's pin on her successor, the newly installed Mrs. Herbert Van Epps, and turned over the gavel to her.

In her inaugural address, the new President asked the question: "Have you earned the right to be a doctor's wife?" She described as her theme for 1965-66: "Hear Auxiliary, See Auxiliary, Speak Auxiliary." She spoke of the importance of studying the health needs of the individual communities and then doing something about them. She urged that "by our thoughts, words and actions, let us be a credit to our husbands." She acknowledged the wonders of the space program, but she warned that doctors' wives must keep down to earth. And she closed her inaugural address with ten significant words: "Do not criticize, condemn or complain—act constructively, think constructively."

Immediately following Mrs. Van Epps' inaugural address, the twenty-fifth session of the House of Delegates to the Woman's Auxiliary of the Ohio State Medical Association was declared adjourned.

#### "Around the World"

Thursday's luncheon honored the new State Officers, National Officers, Out-of-State Guests, County Presidents and Presidents-Elect. Tuscarawas County Auxiliary, home county of the new President, served as hostess. It was a case of "around the world" in 29½ days and some 22,000 miles, when Jerrie Mock captivated her audience and took it with her in fancy on that memorable flight. Mrs. Mock was the first woman to fly solo around the world.

A Workshop on Program Planning followed the luncheon at which Mrs. Van Epps presided. The committee chairmen were on hand to answer questions and to outline their particular activities. The purpose of the workshop was to give county presidents and presidents-elect a boost in setting up their 1965-66 programs.

The Woman's Auxiliary took a long and satisfied look backward this twenty-fifth convention. Now it is looking forward — with hope, with determination, with zeal.



# Ad Astra

**George Washington Cooper, M.D.**, Waverly and Piketon; University of Louisville School of Medicine, 1925; aged 76; died May 11; member of the Ohio State Medical Association and the American Medical Association. A resident of the area for many years, Dr. Cooper practiced in Clarksburg, Ross County, from 1928 to 1950, when he moved to the Pike County community. He was a veteran of World War I and was a member of the Masonic Lodge. Surviving are his widow and four sisters.

**R. Dale Dickson, M.D.**, Topeka, Kansas; University of Kansas Medical School, 1937; aged 55; died May 25; former member of the Ohio State Medical Association. Dr. Dickson resided for a short time in Gibsonburg and practiced in the Sandusky County-Lucas County area. He entered service during World War II and later returned to Kansas to practice.

**Otto Margraf Hattendorf, M.D.**, Cincinnati; Eclectic Medical College, Cincinnati, 1920; aged 71; died May 13. A practitioner of long standing in the Cincinnati area, Dr. Hattendorf retired in 1950 and for about eight years made his home in Florida. Survivors include his widow and a son, Dr. Warren Hattendorf, of Northside, in the Greater Cincinnati area.

**Benjamin Lee Hawkins, M.D.**, Cincinnati; Ohio State University College of Medicine, 1939; aged 50; died May 7; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Orthopaedic Surgeons; Diplomate of the American Board of Orthopaedic Surgery. A practicing physician for many years in Cincinnati, Dr. Hawkins was team physician for the Cincinnati Royals. He was a veteran of World War II, having served in the Medical Corps, in which he attained the rank of major. Affiliations included memberships in several Masonic orders, the Rotary Club, a local boat club, and the Lutheran Church. Surviving are his widow, two daughters and three sons; also a sister.

**John Joseph Hesselbrock, M.D.**, Cincinnati (Kenwood); University of Cincinnati College of Medicine, 1945; aged 49; died May 26; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. Staff member of Our Lady of Mercy and Bethesda Hospitals, Dr. Hesselbrock in January gave up his private practice of 17 years in Silverton. He was a member of the Catholic Church. Surviving are his widow, a daughter, a son, his mother and a brother.

**Elmer Alexander Klein, M.D.**, Cincinnati (Norwood); University of Cincinnati College of Medicine, 1912; aged 78; died May 7; member of the Ohio State Medical Association, the American Academy of Orthopaedic Surgeons, and the Clinical Orthopaedic Society. A native of nearby Covington, Ky., Dr. Klein practiced for about 45 years in the Greater Cincinnati area, specializing in orthopaedic surgery. He served in the Army Medical Corps during World War I. Affiliations included membership in the Masonic Lodge. Two nephews survive.

**Carl Thurston Korsmo, M.D.**, Akron; Temple University School of Medicine, 1941; aged 49; died May 8; member of the Ohio State Medical Association, the American Medical Association and the American Academy of Ophthalmology and Otolaryngology. An Akron practitioner since 1949, Dr. Korsmo was an eye, ear, nose and throat specialist. During World War II he was in the Army Medical Corps and served in Europe. Among organizations in which he maintained memberships was the American Legion. Survivors include his widow, two sons, his mother and two brothers.

**Robert Barthold Reed, M.D.**, Fairborn; Ohio State University College of Medicine, 1920; aged 68; died May 28; former member of the Ohio State Medical Association. A former practicing physician in Fairborn, Dr. Reed died after a long illness. He was a member of the Masonic Lodge. Two brothers survive.

**Harry Langdon Rockwood, M.D.**, Cleveland (Shaker Heights); Western Reserve University School of Medicine, 1909; aged 87; died May 12; member of the Ohio State Medical Association and the American Medical Association. Long associated with public health work and with hospital administration, Dr. Rockwood was Cleveland health commissioner from 1918 to 1930. He was superintendent of the former Warrensville Tuberculosis Sanatorium, was medical director of Mount Sinai Hospital, and from 1946 to 1949 was medical director of what is now Highland View Hospital. He was a past-president of the Ohio Hospital Association. Two sons survive.

**Charles P. Scanlon, M.D.**, Cleveland; St. Louis University School of Medicine, 1926; aged 63; died May 9; member of the Ohio State Medical Association. A practicing physician for some 39 years in the Cleveland area, Dr. Scanlon specialized in obstetrics and gynecology. During World War II, he served

with the Army Medical Corps. Two physician sons survive, Dr. Patrick J., a resident in Cleveland, and John C., a June graduate of Loyola University School of Medicine. Also surviving are his widow, a brother and a sister.

**Adelbert Henry Seiple, M. D.,** Warren; Western Reserve University School of Medicine, 1925; aged 64; died May 4; member of the Ohio State Medical Association and the American Medical Association. A lifelong resident of Warren, Dr. Seiple began his practice there in 1927. He was a veteran of World War I. Affiliations included a 50-year membership in the Methodist Church and membership in the Buckeye Club of Warren. Survivors include his widow, two sons, two brothers and two sisters.

**Demba Morton Spicer, M. D.,** Oakland, Calif. (formerly of Cleveland and Lakewood); Western Reserve University School of Medicine, 1904; aged 87; died May 9; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician of long standing in the Greater Cleveland area, Dr. Spicer retired in 1959 and moved to California. He was a 32nd Degree Mason and a member of the Kiwanis Club. Survivors include a daughter with whom he made his residence, and two sisters.

**John Benjamin Walker, M. D.,** Canton; Howard University College of Medicine, 1919; aged 76; died May 11; former member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of General Practice. A general practitioner in Canton since 1920, Dr. Walker was active in numerous community and civic projects. He was one of the organizers of the Canton Urban League, was a member of the Canton Welfare Federation and Community Chest; he was a past-president of the Stark County Tuberculosis and Health Association; was a member of the Board of the YMCA, a member of the Christian Church, and numerous other organizations. Survivors include his widow, a son, a daughter and a step-daughter.

**Walter Whayne Webb, M. D.,** Dayton (Kettering); Northwestern University Medical School, 1933; aged 58; died May 9; member of the Ohio State Medical Association, the American Medical Association, American Academy of Ophthalmology and Otolaryngology, American Laryngology, Rhinology and Otolaryngology Society; Fellow of the American College of Surgeons; Diplomate of the American Board of Otolaryngology. A practicing physician in the Dayton area, Dr. Webb was a specialist in ear, nose and throat work. Affiliations included membership in the Presbyterian Church and several Masonic bodies. A veteran of World War II, he is survived by his widow and his mother.

**Otto W. Wilton, M. D.,** Cincinnati; medical degree from the University of Vienna, 1927; aged 62; died June 2; member of the Ohio State Medical Association and former member of the American Medical Association. A former practitioner in Austria, Dr. Wilton came to this country in 1939. His private practice in Cincinnati dates to 1943. A member of the Catholic Church and the Knights of Columbus, he is survived by his widow, two sons and a daughter.

**Elias Wesley Woodruff, M. D.,** Harlingen, Texas (formerly of Martins Ferry); University of Virginia School of Medicine, 1906; aged 83; died April 29; former member of the Ohio State Medical Association. A former practicing physician in Martins Ferry and Wheeling, W. Va., Dr. Woodruff specialized in the field of ear, nose and throat work. Survivors include a daughter, a son and a brother.

Link Foundation, established by Edward A. Link, inventor of the Link Trainer, has given Ohio State University College of Medicine a \$2000 grant. According to Dr. Frederick H. Shillito, professor and acting chairman of the department of preventive medicine, the grant will support a fellowship in aerospace medicine. Recipient of the award will be named in July.



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# Activities of County Societies . . .

## ALLEN

A joint recommendation on booster doses of oral polio vaccine was issued to the press by the Academy of Medicine of Lima and Allen County and the Allen County Health Department. Dr. Robert S. Oyer, health commissioner, in making the announcement reported that oral vaccine would not be available through the health department, but through physicians' offices.

Sixty-five members and guests were present for the regular meeting of the Academy of Medicine of Lima and Allen County on May 18. Dr. James Christie, associate professor of radiology at Western Reserve University School of Medicine, gave an interesting and highly informative discussion on "Scintiscanning." — T. D. Allsion, Secretary-Treasurer.

## BUTLER

Dr. Thomas E. Shaffer, Columbus, was principal speaker on "The Adolescent Athlete," at the May meeting of the Butler County Medical Society, held at the Hamilton Elks Club.

Dr. Shaffer is a member of the Medical Aspects of Sports Committee of the American Medical Association and serves as coordinator for Adolescents Health Services at Children's Hospital in Columbus.

## CLINTON

Clinton County Medical Society met Tuesday evening, April 27, for dinner in the Clinton Memorial Hospital dining room and heard a program presented by Dr. Wesley Furste, assistant professor of clinical surgery, Ohio State College of Medicine.

He spoke about the prevention and treatment of tetanus and gas gangrene in wound management. — *Wilmington News-Journal*.

## CUYAHOGA

Better house officer training programs in small community hospitals were urged by Dr. Middleton H. Lambright in his report as outgoing president of the Academy of Medicine of Cleveland.

Dr. Lambright also called for less expensive insurance coverage for individuals and groups, in his address at the organization's annual meeting at the Mid-Day Club.

Dr. Lambright was succeeded by Dr. William F. Boukalik, medical director of St. Alexis Hospital.

Dr. David Fishman, head of the Department of Gastroenterology at St. Luke's Hospital, was named president-elect. Dr. Elden C. Weckesser, surgeon and faculty member of Western Reserve University School of Medicine, was elected vice-president, and director for a second term. Dr. Fred R. Kelly, general practitioner of the staff of Woman's Hospital, was reappointed secretary-treasurer.

Distinguished memberships in the Academy were given to Dr. David A. Chambers, Dr. Russell B. Crawford and Dr. Bruno Gebhard.

Special honors went to Josephine Robertson for her services as medical writer for *The Plain Dealer* for nearly 30 years. She was especially congratulated for a series on medical education, which was reprinted and distributed by the academy to many high school and college students to promote interest in medicine as a career.

Donald J. Dunham, who retired last year as medical writer of the *Cleveland Press*, also was honored.

A third award went to Dr. Thomas F. Healy,

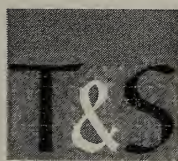
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dentist, for his follow-up studies of the effects of fluoridation of the city water supply.

Dato Ong Yoke Lin, Malaysian ambassador to the United States, was guest speaker.—*The Plain Dealer*.

#### GEAUGA

The Geauga County Medical Society donated a library cart to the Geauga Community Hospital. Books, paperbacks and magazines, donated by friends, are made available twice a week to hospital patients. The Auxiliary operates the service.

#### HAMILTON

Results of annual elections of the Academy of Medicine of Cincinnati were announced by Dr. John J. Cranley, president, at the President's Ball held at the academy headquarters, 322 Broadway.

Dr. Robert M. Woolford, who was named president-elect a year ago, will succeed Dr. Cranley at the annual meeting in September.

Dr. Elmer R. Maurer, who was unopposed, will succeed Dr. Woolford as president-elect, starting in September.

Other successful candidates, all of whom will take office in September, are Dr. Joseph Lindner Jr., secretary; Dr. Stanley D. Simon, treasurer; Dr. William A. Moore, trustee for three-year term; and Dr. William G. Ahlering, councilman-at-large, three-year term.

Elected delegates to the Ohio State Medical Association for four-year terms are Drs. Harry K. Hines, Carl W. Koehler, Charles A. Sebastian and Frank P. Cleveland. Alternate delegates to the OSMa for four-year terms are Drs. Robert S. Heidt, Warner A. Peck, Joseph J. Podesta and Glen W. Pfister Jr. — *Cincinnati Enquirer*.

#### HARDIN

Desperate need for more doctors in the Hardin county area was discussed along with progress being made by the Hardin County Medical society in efforts to attract new physicians to the area at the meeting of the Hardin County Medical society at San Antonio hospital, recently.

It was revealed that a local bank has offered its help in locating new doctors here.

The society also unanimously supported a resolution favoring a comprehensive sex education program in area schools. The Mental Health committee preliminary report emphasized the need for psychological counselling facilities available to children and teen-agers in the area.

Two representatives of a Dayton business management firm spoke to a group about the business side of medical practice. — *The Kenton Times*.

#### LUCAS

The May program of the Academy of Toledo and Lucas County contained the following features:

May 6, General Section — "Syphilis Seminar," Dr. Arthur Curtis, University of Michigan, and Dr. A. P. R. James, Toledo.

May 21, Ohio Orthopedic Meeting — An afternoon session, dinner and evening program for all physicians interested. Sessions at the Academy Building.

May 25 — Toledo Obstetrics and Gynecology Society Annual Meeting — Held at the Academy Building; guest speaker, Dr. Carl Parker Huber, professor of obstetrics and gynecology, University of Indiana.

#### MAHONING

The Rev. Thomas J. O'Donnell, S. J., regent of the Georgetown University Schools of Medicine and Nursing, and of Georgetown University Hospital, was program speaker for the second annual dinner meeting of clergymen and physicians sponsored by

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the Mahoning County Medical Society. Topic for discussion was "The Use of Oral Progestational Drugs and Contraception."

Members of surrounding County Medical Societies were invited to the June 15 meeting of the Mahoning County Medical Society. Speaker was Dr. Irwin W. Bean, of Saskatchewan, Canada, who was president of the College of General Practitioners of Canada in 1962 at the time of the "trouble" in the Saskatchewan area. A social hour and dinner preceded the program.

#### MERCER

The Mercer County Medical Association entertained members of the Mercer County Bar Association at a steak dinner at Northmoor Country Club Thursday (May 27).

Presiding were the presidents of the two groups, Dr. Robert W. Albers and Judge Homer Hinders.

An attorney Russell Volkema, Columbus, spoke on Professional Malpractice, which was followed by a lively discussion by members of both organizations. — *The Daily Standard*, Celina.

#### MONTGOMERY

Dr. W. J. Lewis was named Wednesday (May 27) to become president-elect of the Montgomery County Medical Society. He will serve as president in 1967.

Next year's president will be Dr. Charles E. O'Brien, who is now president-elect. The current president is Dr. Mason S. Jones.

Besides Drs. O'Brien and Lewis, the following were announced as having been elected officers for 1966 at the society's 116th annual meeting held at Wright-Patterson Air Force base:

Dr. Peter Granson, vice-president; Dr. Albert B. Huffer, secretary; Dr. Don E. Sando, treasurer; Dr. Richard S. Graves, trustee; Dr. William M. Porter, delegate for a five-year term and Dr. John R. Keys, alternate delegate. — *Dayton Daily News*.

#### SUMMIT

The May 4 meeting of the Summit County Medical Society was held at Children's Hospital, Akron. Dr. Michael McCally, civilian medical authority attached to the 6570th Aerospace Medical Research Laboratory, Wright-Patterson Air Force Base, Dayton, spoke on the subject, "Medical Problems Associated with Space Exploration." The evening program was preceded by dinner at the Akron City Club.

#### TRUMBULL

Members of the Trumbull County Medical Society met on May 19 at the Trumbull Country Club, with the Auxiliary. Following a social hour and dinner, a scientific program was held, centered around a movie on rehabilitation of the paraplegic patient.

The name of the Lake County Memorial Clinic has been changed to the Dr. Benjamin S. Park Cancer Clinic, in honor of Dr. Park who died recently after devoting much of his time to cancer work and helping to found the clinic.

## WHAT TO WRITE FOR

Some booklets, pamphlets, and other published material available for the asking or at nominal expense and suitable for the physician's office, library or waiting room or for his personal information.

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**Coronary Care Units.** A new 40-page brochure is directed to hospital administrators and health professionals concerned with hospital care primarily of acute myocardial infarction patients. Single copy free from U. S. Public Health Service, Washington, D. C. 20201. In quantity, 20 cents each or \$15.00 per hundred from Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

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**Training the Patient in the Bulb Syringe Method of Colostomy Irrigation.** 25-page publication, 50 cents each; Publication Unit, Institute of Physical Medicine and Rehabilitation, 400 East 34th Street, New York, N. Y. 10016.

Three Ohio State University College of Medicine faculty members recently participated in a seminar for aviation medical examiners at the University of California San Francisco Medical Center. They are Dr. Charles E. Billings, Jr., Dr. Harry Chovnick and Dr. Richard H. Wehr.

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**Committee on School Health**—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Paul D. Hahn, New Philadelphia; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Lawrence L. Maggiano, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Albert E. Thielen, Cincinnati; Homer B. Thomas, Gallipolis.

**Committee on Traffic Safety**—N. J. Giannestras, Cincinnati, Chairman; Howard W. Brettell, Steubenville; Drew L. Davies, Columbus; Clark M. Dougherty, New Philadelphia; Wesley L. Furste, Columbus; Thomas W. Morgan, Gallipolis; Lester G. Parker, Sandusky; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus; John F. Tiltotson, Lima; Robert C. Waltz, Cleveland; Paul L. Weygandt, Akron; Robert E. Zipf, Dayton.

**Committee on Workmen's Compensation**—H. P. Worstell, Columbus, Chairman; A. L. Berndt, Portsmouth; Thomas H.

Brown, Jr., Toledo; Charles A. Browning, Jr., Bellefontaine; Oscar W. Clarke, Gallipolis; Frederick A. Flory, Columbus; Lawrence T. Hadbavny, Cleveland; Clyde O. Hurst, Portsmouth; Edmund F. Ley, Tiffin; Joseph Lindner, Sr., Cincinnati; John D. Osmond, Jr., Cleveland; James G. Roberts, Akron; George L. Sackett, Sr., Painesville; William V. Trowbridge, Cleveland; Rex H. Wilson, Akron; James N. Wychgel, Cleveland; Joseph H. Shepard, Columbus.

**OSMA Members of the Joint Advisory Committee on Athletic Injuries**—Robert J. Murphy, Columbus; John R. Jones, Toledo; Sol Maggied, West Jefferson; Charles H. McMullen, Loudonville; Carey B. Paul, Jr., Columbus; Thomas E. Shaffer, Columbus; Don A. Kelly, Cleveland; Marvin R. McClellan, Cincinnati; Walter A. Hoyt, Jr., Akron.

**OSMA Members of the Joint Committee on School Bus Driver Examinations**—Carey B. Paul, Jr., Columbus; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus.

### DELEGATES AND ALTERNATES

**Delegates and Alternates to the American Medical Association**—George W. Petznick, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Theodore L. Light, Dayton; Kenneth D. Arn, Dayton, alternate; Edmond K. Yantes, Wilmington; Harry K. Hines, Cincinnati, alternate; John H. Budd, Cleveland; P. John Robeck, Cleveland, alternate; Richard L. Meiling, Columbus; Robert E. Tsebantz, Canton, alternate; Paul F. Orr, Perryburg; Frederick P. Osgood, Toledo, alternate; Charles A. Sebastian, Cincinnati; J. Robert Hudson, Cincinnati, alternate; Edwin H. Artman, Chillicothe; Philip B. Hardymon, Columbus, alternate. Delegate to take office Jan. 1, 1966, Frederick P. Osgood, Toledo; alternate, Robert N. Smith, Toledo.

## COUNTY SOCIETIES' OFFICERS AND MEETING DATES

### First District

Councillor: Robert E. Howard, Cincinnati 43202  
2600 Union Central Bldg.

**ADAMS**—Gary J. Greenlee, President, Farmers National Bank Bldg., Manchester; Stanley H. Title, Secretary, Seaman.

**BROWN**—John A. Powell, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown. 3rd Sunday, monthly.

**BUTLER**—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton. 4th Wednesday.

**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.

**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p. m., monthly, Clinton Memorial Hospital.

**HAMILTON**—John J. Cranley, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday, Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

**WARREN**—O. Willard Hoffman, President, 20 E. Fourth St., Franklin; Ray E. Simendinger, 901 Broadway St., Lebanon.

### Second District

Councillor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

**CHAMPAIGN**—Isador Miller, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.

**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Eickensaff, Secretary, 29 East Wood Street, Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

**SHELBY**—George J. Schroer, President, 322 Second Ave., Sidney; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney.

### Third District

Council: Frederick T. Merchant, Marion 43305  
1051 Harding Memorial Pky.

**ALLEN**—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima. 3rd Tuesday, monthly, except June, July and August.

**AUGLAIZE**—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville. Called meetings.

**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.

**HANCOCK**—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.

**HARDIN**—Glen B. Van Atta, President, 900 East Franklin Street, Kenton; J. J. Rogot, Secretary, Ballie Center. 2nd Tuesday, monthly, except June, July and August.

**LOGAN**—Richard A. Firmin, President, Zanesfield; Ernest J. Hanson, Secretary, 128 W. Baird St., West Liberty. 1st Friday, monthly.

**MARION**—James A. McGlew, President, 399 E. Church St., Marion; Lester E. Wall, Secretary, 817 S. Main St., Marion. 1st Tuesday, monthly.

**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.

**SENECA**—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.

**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.

**WYANDOT**—Franklin M. Smith, President, E. Saffle Ave., Box 68, Sycamore; Robert E. Goynne, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

### Fourth District

Councillor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

**DEFIANCE**—John W. Cullen, President, Box 218, Defiance; William S. Busted, Secretary, Box 218, Defiance. 1st Saturday, monthly.

**FULTON**—Benjamin H. Reed, Jr., President, 101 Adrian St., Delta; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon. 2nd Tuesday, March, June, September and December.

**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon. 1st Tuesday, monthly.

**LUCAS**—R. Philip Whitehead, President, 424 W. Woodruff Ave., Toledo 43602; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday.

**OTTAWA**—Robert Reeves, Port Clinton Road, Oak Harbor; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.

**PUTNAM**—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Lugibihl, Secretary, Pandora. 1st Tuesday monthly.

**SANDUSKY**—J. L. Zimmerman, President, Memorial Hospital, Fremont; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.

**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

**WOOD**—Louis P. Baldoni, President, 195 E. Broadway, Perrysburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

## Fifth District

Councilor: P. John Robeck, Cleveland 44106  
10525 Carnegie Ave.

**ASHTABULA**—Harmon O. Tidd, President, 362 Rogers Place, Ashtabula; William F. Doran, Secretary, 241 Mill St., Conneaut. 2nd Tuesday, monthly.

**CUYAHOGA**—Middletown H. Lambright, Jr., President, 10616 Euclid Avenue, Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland, 6.

**GEAUGA**—Simon Onanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

## Sixth District

Councilor: Edwin R. Westbrook, Warren  
438 North Park Ave.

**COLUMBIANA**—Peter Cibula, President, 356 E. Lincoln Way, Lisbon; Ernest P. Schaefer, Secretary, 190 Penn Ave., Salem. 3rd Tuesday, monthly.

**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.

**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARK**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., Canton 44702. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

## Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry  
30 S. 4th St.

**BELMONT**—Robert N. Lewis, President, 100 W. Main Street, St. Clairsville; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.

**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.

**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

**MONROE**—Byron Gillespie, Secretary, S. Main St., Woodsfield.

**TUSCARAWAS**—H. Winston, President, 658 Boulevard, Dover; G. W. Johnston, Secretary, 658 Boulevard, Dover. 2nd Thursday, monthly.

## Eighth District

Councilor: Robert C. Beardsley, Zanesville  
2236 Maple Ave.

**ATHENS**—Robert E. Main, President, 400 East State Street, Athens; Lester A. Hamon, Secretary, 400 East State Street, Athens. 2nd Tuesday at noon, monthly.

**FAIRFIELD**—Victor A. Simele, President, Equitable Building, Lancaster; Stephen R. Hodson, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Seneca; Dayle O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.

**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Fowleson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

**NOBLE**—F. M. Cox, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.

**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.

**WASHINGTON**—Donald Fleming, President, Vincent; Archbold M. Jones, Jr., Secretary, 326 Third St., Marietta.

## Ninth District

Councilor: George N. Spears, Ironton  
2213 S. 9th St.

**GALLIA**—Leonard Harris, President, Holzer Clinic, Gallipolis; James A. Kemp, Secretary, Holzer-Clinic, Gallipolis. Quarterly meetings at called times.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

**JACKSON**—A. R. Hambrick, President, Wellston; John C. MacLennan, Secretary, Oak Hill. Meeting date varies.

**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

**MEIGS**—Selim J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once monthly.

**PIKE**—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.

**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

## Tenth District

Councilor: Richard L. Fulton, Columbus 43212  
1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

**FAYETTE**—Thomas J. Hancock, President, 220 E. Market St., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 2nd Friday, monthly.

**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

**ROSS**—Paul F. MacCartor, President, 60 Central Center, Chillicothe; Robert L. Counts, Secretary, 56 E. Second St., Chillicothe.

**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

## Eleventh District

Councilor: William R. Schultz, Wooster  
1800 Beall Ave.

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Clem Chalfant, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.

**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P.O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

**HOLMES**—Owen F. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.

**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.

**MEDINA**—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Stanley L. Brody, President, 327 Park Ave W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.



## Classified Advertisements (Contd.)

FOR SALE to settle doctor's estate. Full length, top quality Autumn Haze \$4,000.00 Mink coat, size 14-16, recently purchased from prominent New York Furrier. Price, \$2,800. Box 418, c/o Ohio State Medical Journal.

GENERAL PRACTICE OFFICE AND HOUSE FOR SALE. Excellent location (across from Magic City Shopping Center), no parking problem, records included; leaving Ohio in end of June. Building newly remodeled; contains office and 2 apartments. Located 202 Wooster Rd., North. Barberton, Ohio 44203, Phone 753-7271.

PROGRAM-TRAINING-RESEARCH DIRECTOR for 150 bed intensive treatment hospital. Seven full time psychiatrists on staff. Active out-patient service. Requires dynamically oriented psychiatrist with desire and ability to plan and implement programs, be responsible for training and research. An exciting position for the right man. Salary dependent on qualifications. Apply to: William Polanka, M. D., Superintendent, Summit County Receiving Hospital, Cuyahoga Falls, Ohio.

### HEALTH COMMISSIONER for MASSILLON, OHIO

The City of Massillon is in need of a full time person with education and experience in public health; he must be a good administrator. Salary range \$7000 to \$10,000 per annum. Send application to: Massillon Board of Health, City Hall, Massillon, Ohio.

GENERAL PRACTITIONER to associate with well established two man group, Northeastern Ohio, on Lake Erie; city of 30,000. New building, modern hospital facilities adjacent. Box 411, c/o Ohio State Medical Journal.

FOR RENT: Office suite in building with G. P. and dentist in adjacent suites. The New Philadelphia-Dover area; a community of around 22,000. Write Box 423, c/o Ohio State Medical Journal.

WANTED -- STAFF PHYSICIANS (3): General practitioners 45 or under to assist attending staff and general practice residents in 260 bed general hospital. Annual appointment preferred. \$15,000 - \$17,500 depending on training and experience. Contact Medical Director, San Luis Obispo General Hospital, San Luis Obispo, California. Phone: 805-543-1500.

INTERNIST WANTED to associate with well established two man group, Northeastern Ohio, on Lake Erie; city of 30,000. New building, modern hospital facilities adjacent. Box 412, c/o Ohio State Medical Journal.

OFFICE SPACE FOR RENT: Two examining rooms; complete office equipment; x-ray; fluoroscope; reception room; air-conditioned medical building; ground floor; parking. Established practice for over 15 years; physician deceased; records available; 5,000 to 6,000 patients. Near three hospitals. West side of Cleveland. Please contact Mrs. Harold Riser, 14601 Puritas Rd., Cleveland, Ohio 44135. Telephone: 941-3282.

ANESTHESIOLOGIST. Seven years experience, desires group. Details first letter. Box 424, c/o Ohio State Medical Journal.

FOR SALE: Office equipment, waiting room furniture, autoclave and numerous small tools. Donald B. Lucas, M. D., Rt. 4, Delaware, Ohio. Phone: 548-2244.

FOR SALE: Kelly Kett X-ray and fluoroscope unit and all accessories; 2 diathermy machines; 2 examining tables; surgical instruments; Castle 12" autoclave and sterilizer; electric cauterization set; 2 weighing scales, and miscellaneous items. A. H. Franks, M. D., 979 Copley Road, Akron, Ohio 44320. Telephone 836-7800.

URGENT NEED for general surgeon, OB-GYN man or generalist. New modern offices located adjacent to modern hospital serving radius of 40,000 people. Stimulating, rewarding practice available at once. Oak Hill Medical Associates, Box 316, Oak Hill, Ohio 45656.

RADIUM FOR SALE: 90 milligrams in 10 milligram platinum-iridium needles, adaptable to Ernst Applicator. Excellent quality. Box 425, c/o Ohio State Medical Journal.

GENERAL PRACTICE OR INTERNAL MEDICINE: Opportunity available in Mt. Vernon, Ohio (Knox County). Two hospitals in town, two blocks and four blocks from completely furnished modern seven room office. Office available immediately on a lease basis. Complete equipment available on a rent/option to purchase basis. Write: 115 E. Gambier St., Apt. C., Mt. Vernon, Ohio or call Mt. Vernon, 392-3651.

### Columbus Surgeon Accorded Honors In England and in France

Dr. Robert M. Zollinger, professor and chairman of the Department of Surgery in the Ohio State University College of Medicine, has been inducted as an honorary fellow of the Royal College of Surgeons of England. He received the honor June 9. The previous week the university surgeon received an honorary doctorate from the University of Lyon, France.

Dr. Zollinger is past president of the American College of Surgeons, American Surgical Association, Society of University Surgeons, Central Surgical Association, Society for Surgery of the Alimentary Tract, Interstate Postgraduate Medical Association of North America and the Society for Medical Consultants in World War II. In 1964, he served as executive vice president of the Pan American Medical Association.

Beginning in October, Dr. Zollinger will become president of the American Rose Society for a two-year term.

Dr. Alan R. Moritz has been elected provost of Western Reserve University, a post in which he will be chief administrative officer for all educational, research and student services at the university. He is retiring from his other positions of responsibility at the university to give full time to the new assignment.

Dr. Jack Schreiber, of Canfield, has been named to the Board of Directors of Wittenberg University, Springfield.

### Researchers Study Plastics For Artificial Organs

Blood clotting and other undesirable effects often result when synthetic materials are used in the human body, for example in artificial organs, artificial arteries, etc. Research is currently proceeding at Battelle Memorial Institute, in Columbus, under auspices of the National Heart Institute, to perfect a procedure that will allow addition of some kind of surface to plastics used in contact with the blood.

An article entitled "Problems of Body Acceptance of Plastics," was published in the June issue of the Battelle Technical Review. Copies of this article may be obtained by writing: Publications Office, Battelle Memorial Institute, 505 King Avenue, Columbus, Ohio 43201.

### COMING MEETINGS

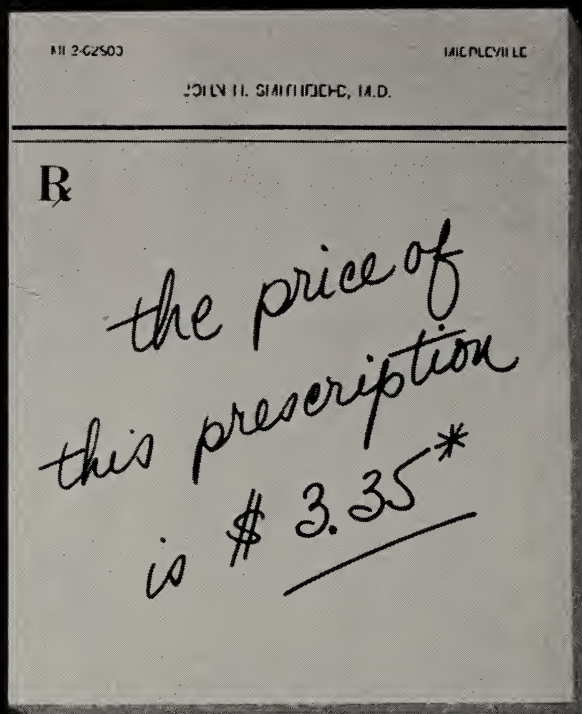
#### Ohio State Medical Association:

- 1966 Annual Meeting, Cleveland, Week of May 22.
- 1967 Annual Meeting, Columbus, Week of May 14.
- 1968 Annual Meeting, Cincinnati, Week of May 12.

#### American Medical Association:

- 1965 Clinical Convention, Philadelphia, Nov. 28-Dec. 1.
- 1966 Annual Convention, Chicago, June 26-30.

Ohio Academy of General Practice, 15th Annual Scientific Assembly, Toledo, August 17-19.



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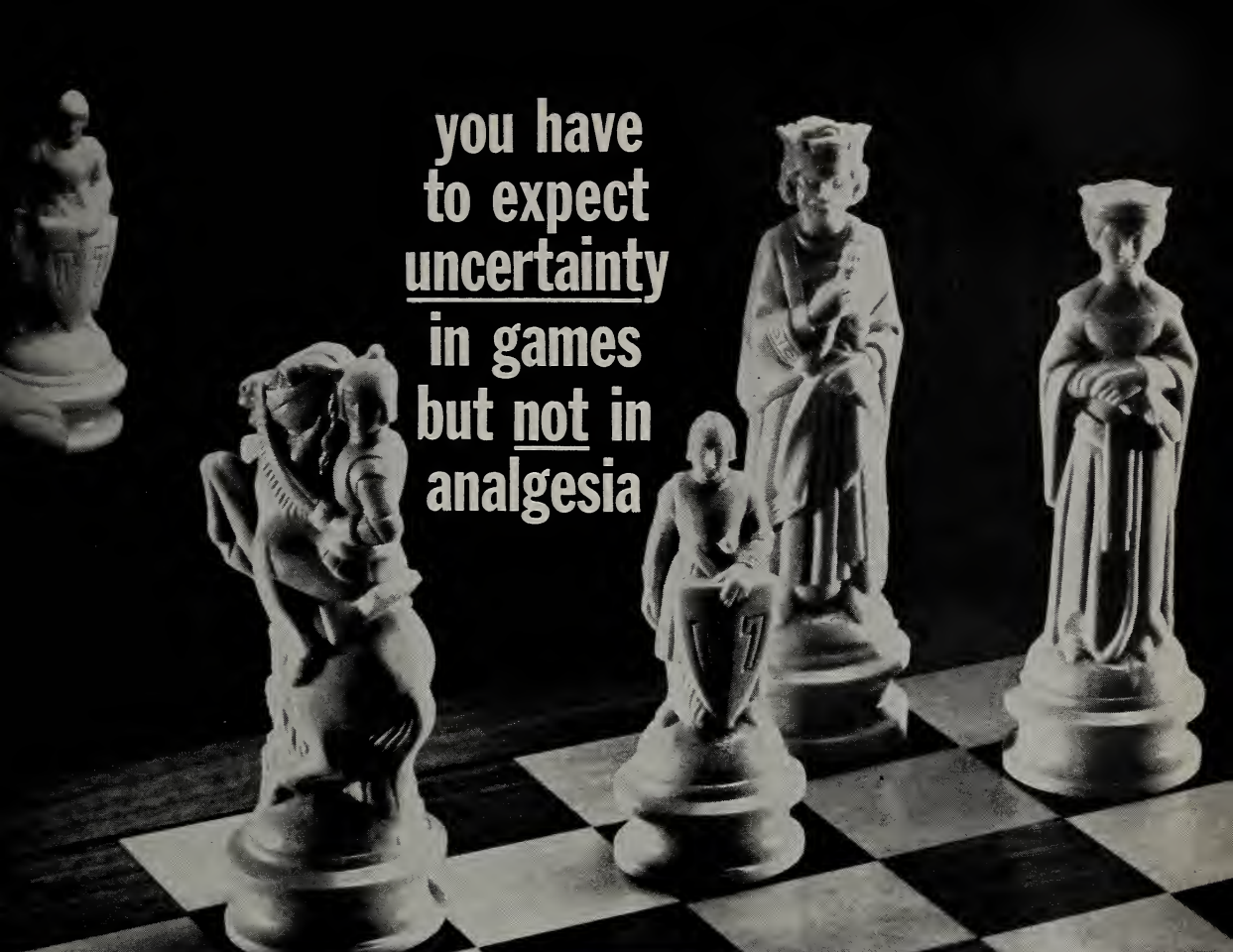
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*This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.*

\*Average prescription price, 1963. National Prescription Audit, R.A. Gosselin, Dedham, Mass.





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## Current Comments in the Field Of the Drug Manufacturers

The following excerpts of comments from various sources are presented in behalf of the Pharmaceutical Manufacturers Association and drug manufacturing firms in general.

\* \* \*

The rigid legalistic terms of the 1963 (drug) regulations have alerted legal consultants and administrators in every research organization in the country. Each man reads and has a different interpretation depending on his background. Patient consent for the trial of new drugs is now strongly suggested and is so fraught with ethical, sociological, and educational problems that the clinical pharmacologist must become a master diplomat if he wasn't born this way. — Carl C. Pfeiffer, Ph. D., M. D., in *Journal of New Drugs*, 4:6, (Nov.-Dec.) 1964.

\* \* \*

To a member of the clinical research staff of a pharmaceutical manufacturer, the impact of the new drug law and F.D.A. regulations has been overwhelming. The immediate and unprinted reaction reflects the enormous increase in paper work and the infinite detail that are now demanded of the individual responsible for the clinical development of a drug for a pharmaceutical manufacturer . . . You have all been regaled by accounts of the size of the current new drug applications. Our latest weighed 550 pounds, and is by no means a record. Sending in supplementary case data on that particular application involved reproducing, collating and forwarding over 80,000 individual sheets of paper! — Irwin C. Winter, Ph. D., M. D., in *Journal of New Drugs*, 4:6 (Nov. - Dec.) 1964.

\* \* \*

Although there may be a need for controlling false claims for medical devices, one might well hope that the haste which resulted in the new laws and regulations about drugs will not serve as a pattern for

legislation related to physical devices. The drug controls, in many respects, appear to go far beyond what is necessary to ensure reasonable safety. Surely, in the final drafting of bills on medical devices, experts in the industry as well as university researchers should be given full opportunity to make available their knowledge and experience. — Morris Fishbein, M. D., in *Medical World News*, 6:6, (Feb. 19) 1965.

## Pharmaceutical Manufacturers Set Up Scientific Research Foundation

The Pharmaceutical Manufacturers Association announced that it has established a Foundation to promote the public health through scientific and medical research. PMA's board of directors approved bylaws setting up the Pharmaceutical Manufacturers Association Foundation, Inc. (PMAF).

It has three main purposes:

- (1) To plan and initiate scientific and medical research activities;
- (2) To collect and disseminate to the public results of these activities; and
- (3) To provide financial aid to selected individuals or educational institutions, or corporations' trust funds, or foundations whose purposes are scientific, educational or charitable.

The foundation will begin work on a modest scale, first assembling data on what now is being done in the field by industry, research and educational groups.

As an example of the type of work the foundation might sponsor, it was mentioned that it could take over the administration of color additive tests begun three years ago and supported by some 30 PMA member firms. Also to be considered as a possible foundation activity is the joint sponsorship with the American Medical Association and the Food and Drug Administration of the new Registry for Tissue Reaction to Drugs recently established at the Armed Forces Institute of Pathology.



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C I B A

## Heart Association Announces Research Grants in Ohio

Five fellowship awards and nine grants-in-aid for heart research in Columbus, Cincinnati, and Cleveland are being supported by the American Heart Association for July 1, 1965 - June 30, 1966.

The announcement was made by Dr. John A. Rogers, Youngstown, president of the Ohio State Heart Association.

The Ohio awards are among 297 made by the national association in 36 states and Canada, totaling nearly \$4 million.

In addition, \$6 million will be spent by heart chapters throughout the country for local projects in the year ahead, bringing the heart research total to \$10 million. This sum represents the largest single non-governmental source of cardiovascular research support in the world.

The five Ohio fellowship recipients announced today are among 95 in the country to receive individual support as Established Investigators — scientists of proven ability who are supported for five-year periods.

They are: Dr. Paul Nathan, Cincinnati, May Institute for Medical Research; Dr. Virginia H. Donaldson, Cleveland, St. Vincent Charity Hospital; Dr. Philip W. Hall, III, Cleveland Metropolitan Hospital; and Dr. Gerald P. Brierley, Ph.D., and Dr. Heinz P. Pieper, Columbus, Ohio State University College of Medicine.

Grants-in-aid will support studies by the following: Dr. Gunter Grupp, University of Cincinnati College of Medicine, \$9,295, regulation of blood flow through the kidney; Dr. Paul Nathan, May Institute for Medical Research, Cincinnati, \$7,040, transplantation of the kidney; Dr. John W. Corcoran, Ph.D., Western Reserve University School of Medicine, Cleveland, \$7,150, a study of antibiotic compounds affecting the heart.

Also, Dr. Bernard R. Landau, Western Reserve University, \$8,305, how sugar is metabolized in fatty tissue; Dr. Virginia H. Donaldson, St. Vincent Charity Hospital, Cleveland, \$5,445, clot-dissolving mechanisms in the blood; Dr. Philip W. Hall, III, Cleveland Metropolitan General Hospital, \$5,830, relationship of blood protein chemicals to minerals.

Also, Dr. Salvatore Sancetta, Cleveland Metropolitan General Hospital, \$8,635, effects of body chemicals in the blood stream; Dr. Heinz P. Pieper, Ohio State University College of Medicine, \$9,900, pressure flow in the coronary system; and Dr. Arnold M. Weissler, Ohio State University College of Medicine, \$13,255, study of digitalis.

---

"A List of Current Health Insurance Books, 1965" is available free from the Health Insurance Institute, 277 Park Ave., New York, N. Y. 10017.

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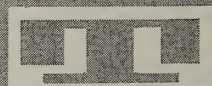
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## Health Insurance Now Protects Large Percent of People

Nearly four out of five Americans have health insurance, and last year these insured persons received \$8.7 billion in benefits.

These were the key findings of the Health Insurance Council's 19th annual survey. The Council, in a report, said that at the end of 1964 more than 151 million persons had hospital expense insurance. Of these persons, 93 per cent also had surgical expense insurance and 72 per cent had regular medical (non-surgical) expense protection.

The Council survey on the extent of voluntary health insurance in the United States is based on reports from insurance companies, government agencies, Blue Cross, Blue Shield, and Medical Society plans. Complete results of the survey will be available soon in booklet form.

The 151,123,000 persons with hospital insurance represent 79 per cent of the civilian population. The total is four million higher than in 1963 when, revised figures show, 147,168,000 persons (78 per cent) were protected.

Benefit payments in 1964 made by all insuring organizations for hospital, surgical and medical care totaled \$7.7 billion, up \$820 million over the 1963 total, the Council reported. In addition, persons with loss-of-income insurance received \$1,012 million in benefits from insurance companies.

The grand total in health insurance benefits came to \$8,697,000,000 for 1964, a record high, and an 11.5 per cent increase over the 1963 total of \$7,801,000,000.

Council statistics show that growth in coverage and benefits has been considerable over the 1954-64 decade. Fifty million more persons were protected by health insurance at the end of 1964 than in 1954 when 101,493,000 persons were insured. Of this number, 84.6 per cent also had surgical insurance and 46.6 per cent had regular medical protection. Benefits in 1964 were nearly six billion dollars more than in 1954 when they totaled \$2,720,000,000.

## National Conference on Sports Philadelphia, Nov. 28

The Seventh National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held in Philadelphia, Pennsylvania, at the Benjamin Franklin Hotel on November 28, 1965. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

Those interested in receiving further information should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

## RITTER One-Piece Waist Height Garment RELIEVES Varicosities of PREGNANCY

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# Butazolidin® brand of phenylbutazone in osteoarthritis

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## Therapeutic effects

A number of investigators report improvement in about 75% of cases. Relief of pain and stiffness is the predominant response. Frequently, there is also a significant improvement in function. The beneficial effects of the drug are usually seen by the third or fourth day of treatment.

There is general agreement that milder cases of osteoarthritis are preferably treated by simple analgesics. In many patients, however, this mode of therapy fails to give sufficient relief. Because steroids are not very effective in this form of arthritis, phenylbutazone affords the drug therapy most capable of relieving the more severe cases. For best results, it is recommended that treatment with phenylbutazone be combined with physiotherapy and other appropriate supportive measures.

## Dosage

The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

## Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and

should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

**Warning:** If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

## Side effects

The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

## Contraindications

These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy;

history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

**Note:** The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

## Butazolidin alka

Each capsule contains:

Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

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# Health Officers of Cincinnati, Ohio And the Problems of Their Day

KENNETH I. E. MACLEOD, M.D., M.P.H.\*

## PART III

(Continued from July Issue)

DR. MINOR'S complete report on the Sanitary Survey of Cincinnati in 1879 occupies almost an entire volume of one bound copy of the annual reports. Those interested in the survey details must make reference to the original, as it is too lengthy a document to brief here. But as expected he makes reference to many items affecting the public health, notably "the crowded conditions of the tenements . . . accountable in part at least for the heavy infantile mortality . . ."

He was also willing to carry out some special research for he includes in the survey report a record of children dying under the age of 2 years from infantile diarrhea. He made special note of the sources of milk of these infants — mother's milk, cow's milk, condensed milk, and artificial patented food.

He noted that the milk supply for the city was derived from some 330 dairies, almost half of which "feed swill to their cows." In 1878 the Health Department forced these dealers to turn out their cattle to pasture during the summer season, at the time the greatest mortality from intestinal disease among children was noticeable.

The relationship of the working conditions of the workers to health is noted in an extensive series of paragraphs. Thus, Dr. Minor notes that workers in iron, exposed to clouds of fine dust and minute particles of metal, suffer from phthisis to a marked degree — the greatest mortality, in proportion to population among adults in cities, times of epidemics excluded, being found among the working classes. He gives many other examples. He notes with some asperity:

The cause of this state of affairs is easily traceable, and could be remedied to a great extent by national legislation. In all of the manufacturing centers of the country cheapness of production is the point aimed at by employers . . . Artisans are too often regarded by their employers as machines,

and the question of their comfort and health is made a mere calculation of profit and loss. The cities and towns are over-supplied with unemployed men, women and children; this supply of workmen exceeds the demand. The result is that labor can at all times be obtained. So long as the majority of workmen are employed at living wages during times of comparative prosperity, the spirit of discontent among the mass of the people is not apparent; but in times of financial depression . . . a spirit of bitterness between labor and capital is more than manifest . . .

In another passage he notes "much ado made by prominent New England sanitarians regarding physical degeneracy among the American-born portion of the population," and their intimation that "heredity is responsible in a great measure for the consumptive tendency . . ." But Dr. Minor indicated his own belief that "overcrowded, ill-ventilated, and badly lighted tenements, constructed on damp, sub-clay soil . . . poor food and sedentary habits are the prime factors in the production of phthisis . . ."

He also noted that the "most common disorders among children attending the public schools" were short-sightedness, headache, dyspepsia, contagious diseases. "There is no doubt," he wrote, "that the public schools are the principal disseminators of scarlatina and diphtheria . . ." But he agreed that "accidents among pupils are rare, the teachers, especially the lady teachers, watching the wards confided to their charge most faithfully . . ."

Because of their importance historically, however, we must include under the title, *Health Services in Cincinnati*, some items in more detail.

### Health Services in Cincinnati in the 1870s

In Dr. Minor's words,

Cincinnati has one large public and three private hospitals and a special hospital for contagious diseases. The city also has a large infirmary. *The Cincinnati (City) Hospital*, controlled by a Board of Trustees . . . is situated on the block bounded by 12th Street, Ann Street, Plum Street and Central Avenue . . . Eight distinct buildings, en echelon connected with each other by corridors . . . The ordinary capacity of the hospital is five hundred beds. The medical management

\*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.

Submitted October 4, 1964.





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*Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects*, usually dose-related, may include

mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions.

Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.



Smith Kline & French Laboratories

of the hospital is in the hands of sixteen physicians, and seven undergraduate or resident physicians—the medical labor being divided among the Surgical, Medical, Obstetrical, Venereal, and Ophthalmological Wards. Medical service is rendered gratuitously by the staff.

During the year 1878, 3,112 patients were treated in the medical and surgical wards; 215 women were also confined in the obstetrical wards (but see below: midwives).

*St. Mary's Hospital*, under the auspices of the Sisters of St. Francis, is located on Betts Street—a large three-story brick building . . . of 300 beds. Medical service is rendered gratuitously by a staff of seven visiting physicians . . .

*The Good Samaritan Hospital*, under the auspices of the Sisters of Charity, was originally built by the U. S. Government, during the late Civil War, for the Marine Service. It was afterwards purchased and given the Sisters, by a couple of wealthy citizens . . . the original cost being estimated at \$500,000. The ordinary capacity is about 175 beds . . .

*The Jewish Hospital*, for the especial benefit of sick Hebrews is a large and commodious two-story building, situated at the corner of Third and Baum Streets. It contains two wards, having an ordinary capacity of 30 beds, besides a dozen private rooms . . .

*The Hospital for Contagious Diseases*—a branch of the Cincinnati (City) Hospital, and under the same auspices, is located on Lick Run Pike . . . The ordinary capacity is 100 beds. This hospital is only used for smallpox patients. The medical service is rendered by a paid physician appointed by the Board of Hospital Trustees.

The total ordinary hospital accommodation of Cincinnati is over 1,000 beds, and is entirely sufficient to meet the wants of the public . . .

In addition to these hospitals, Cincinnati has a large *City Infirmary*, located near Hartwell . . . with an ordinary capacity of 600 beds. It is filled by aged and infirm paupers, suffering from chronic diseases of various kinds . . .

Cincinnati has five dispensaries, where medicine and medical relief are dispensed gratuitously. Four of these . . . are established in connection with medical colleges, and one is carried on under the management of the Sisters of Charity . . .

The Health Department also furnishes medicine and medical attendance to the sick poor of each ward in the city—25 district physicians on salary, paid by the Board of Police Commissioners, conducting the medical service . . . [See earlier statement on this service.]

The system of charities having reference to the comfort and care of the sick poor is about as perfect as could be desired. Cincinnati, among American cities, can be said to stand pre-eminent in this respect . . .

. . . Cincinnati has been visited severely at times by epidemics. Cholera was prevalent in 1832, 1848-49, 1866, and also to a certain extent in 1873 . . . Sporadic cases of cholera occur every summer . . .

Quarantine, when needed by Cincinnati, is enforced under a State enactment . . . Owing to the peculiar geographic relations Cincinnati bears to the South, it is extremely difficult to devise and enforce a quarantine . . . Quarantine at Cincinnati means a rigorous medical inspection of railroads and boats . . . Yellow fever is a portable disease and all avenues over which it may be carried are carefully watched . . . The river station is placed from ten to twelve miles below the city . . . Ten physicians and twelve sanitary inspectors make up the ordinary force used . . . In case of emergency fifteen extra physicians, holding positions under the Health Board, could be placed on duty in six hours' time . . .

The municipal "sanitary" expenses for the year 1879 (all purposes) totaled \$667,057.54, but this included money for deep drainage, sewerage, paving and repairing streets, street cleaning of vaults, construction and repair of markets, and inspection of food, construction and care of public parks, care of public drinking fountains, the health department's expenses for medical relief and medicines for the sick "out-door" poor, and the quarantine expenses. The strictly public health expenses amounted to some \$35,000, and as the population was about 280,000 this amounted to an expenditure on public health of about 13 cents per capita.

In reviewing Dr. Minor's contribution (brief although his period as Health Officer was) we are impressed, for he was a man of strong integrity, even erudite in knowledge, humanitarian in spirit, with considerable medical acumen and insight. In concluding his final and indeed monumental report, the thirteenth of the department, he noted: "If in any way credit is attached to past management, it belongs to the Board that unanimously supported its Health Officer during every emergency, and gave him full liberty to act as his medical judgment indicated . . ."

#### Dr. A. J. Miles: 1880-1881

The Health Department's brief period of responsibility to the Board of Police Commissioners ended in 1879, and with it Dr. Minor's services. The new Board of Health, as noted in the first annual report of the new health officer, Dr. A. J. Miles, reveals this clearly:

The questions raised, respecting the legal status of your Board in the early part of 1880, threatened for a time to seriously interfere with the performance of the duties of your employees, not on account of any dereliction on this part, but by reason of a disposition on the part of some of our citizens to use these questions as a reason for non-compliance with orders from this office . . .

During the years 1880 and 1881 the city's water supply was a matter of major concern to Dr. Miles and his Board. He noted,

The analyses of water at the pumping works establish the unwelcome fact that the sewage of the city is beginning to contaminate the river-water supply . . . Your committee . . . had brought to attention a plan of filtration which seems practicable, and which commends itself by its simplicity, its comparatively low cost, and by the fact that it does not obstruct the river bed . . .

He was also concerned, as had all of the previous health officers been, with the state of tenement housing

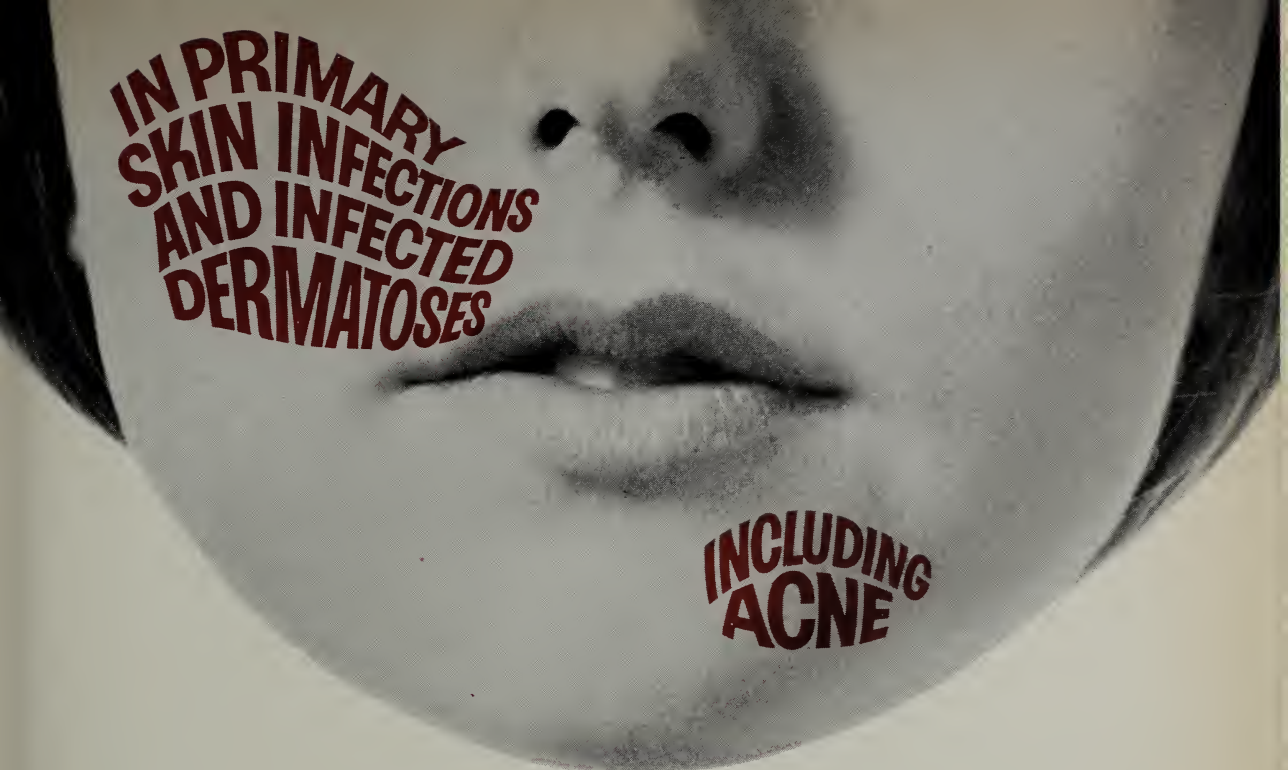
in which the indigent are forced to live in scant quarters . . . and which are the prolific centers from which are propagated disease and crime . . . The good health of an individual, morally and physically, seems to depend, to a certain extent, upon space . . . to breathe and more to move in, without encroaching upon his neighbor . . .

#### Midwives

(See previous paragraphs on Health Services)

During the year 1880 there were 7,945 births in Cincinnati, more than 70 per cent of them attended





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DERMATOSES**

**INCLUDING  
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**the distinctive advantages of DECLOMYCIN include**  
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*Side effects* typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dos-

age in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food, and should not be taken less than one hour before or two hours after meals.

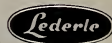
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*Average Adult Daily Dosage*: 150 mg q.i.d. or 300 mg b.i.d. In pustular acne vulgaris, after one or two weeks, dosage may be reduced to 300 mg or 150 mg daily.

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upon by midwives and delivered in the home. There were 360 practicing physicians in the city and 70 midwives. One of the reasons given for the dominant role of the midwife in obstetrics

is that the population of the city is largely German, who are a prolific race, and who generally employ the services of midwives, sending for physicians only in cases of anticipated trouble or difficult labor . . . Another reason, and strong one, with people of limited means is the expense . . .

In a further discussion of the problem of inadequate maternal and child care, Dr. Miles pointed out that "these midwives, as a class, are deficient, both in mechanical and technical training for the important work they perform . . ." He urged the strengthening of the state laws to prohibit "the practice of medicine, by any person not having obtained a diploma from some regularly chartered medical college or a license from a medical society . . ." He noted with approval the plan "adopted by the Obstetrical Society of London, England, for the training and examination of midwives . . ."

#### Abuse of Charity

And, again shades of Newburgh, New York, of recent notoriety, Dr. Miles instructed his staff

to carefully examine the conditions of every applicant for relief and to make the closest scrutiny and inquiry as to their worthiness before drawing upon the officer in charge of the supplies: (but) in no case was relief refused to anyone that was entitled to receive it . . .

#### The Smallpox

In 1881, Dr. Miles had to contend with a particularly heavy outbreak of the smallpox. He noted in his report:

After an interval of five years, smallpox again made its appearance in our city . . . The number of deaths from the disease was 267 . . . That this scourge can be controlled sufficiently to remain in its present place as second among the causes of death during the coming year cannot be expected for several reasons . . . It is humiliating to confess that the ways and means to prevent recurrence of epidemics of this filthy disease are known to us, and that we do not avail ourselves of them . . . The remedy lies in vaccination and re-vaccination . . .

Dr. Miles writes on many subjects — on trichinosis, on rules and regulations governing such items as markets, privies, water closets, tenements, contagious diseases, recording of deaths, meat and vegetables, disposal of trash and garbage, and so on.

#### Dr. D. D. Bramble: 1882

During Dr. Bramble's brief tenure he noted that "the principal diseases treated by the district physicians" were bronchitis, smallpox, intermittent fever (possibly malaria and/or abortus), diarrhea, rheumatism, consumption, general debility, neuralgia, dyspepsia and pneumonia. During 1882, 2,767 patients were treated for these 10 principal causes out of a total of 5,452 individuals.

*(To Be Continued in September Issue)*

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\*Swartz, C., et al.: Circulation 28:1042, 1963.



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## New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during June. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

### Athens

Sigmond J. Konigseder,  
Athens

### Cutler

Pepito A. Aumentado,  
Hamilton  
Kenneth C. Rowley, Hamilton

### Cuyahoga

Haskell M. Heller, Cleveland  
Robert S. Kunkel, Jr.,  
Cleveland  
Deepak N. Pandya, Cleveland

### Franklin

Charles E. Billings, Jr.,  
Worthington  
W. George Bingham, Jr.,  
Columbus  
David E. Morgan, Columbus

### Hamilton

Walter H. Herzog, Cincinnati

### Lake

Richard R. Robie, Wickliffe  
Kenneth E. Shick, Willoughby

### Lucas

Pacifico Geronimo, Toledo  
Howard S. Madigan, Toledo  
Carlisle K. Parker, Jr., Toledo

### Montgomery

Joseph J. Bock, Dayton  
Thomas C. Graul, Dayton  
Robert J. Kemper, Dayton  
Peter Paul Morgan, Dayton

### Summit

Joseph A. Ogonek, Kent

The Committee on Injuries of the American Academy of Orthopaedic Surgeons will hold the Second Postgraduate Course on Fractures and other injuries at the Riviera Motel, Atlanta, Georgia, on October 11, 12, 13 and 14.

## Ohio State University Offers Postgraduate Courses

The Ohio State University College of Medicine has announced a schedule of postgraduate courses for the 1965-1966 season. Following are courses announced for the September-December period.

September 24-25 — Postgraduate Course in Pulmonary Diseases.

October 6 — Tenth Annual Session on Rheumatic Disease.

October 14 — Diabetes Seminar.

October 20 — Pediatric Invitational Seminar (tentative).

October 29-30 — Endocrine Seminar (obstetrics and gynecology).

November 1-24 — Board Refresher Course in Neuropsychiatry.

November 4 — Multiple Sclerosis Clinic Day.

November 7-9 — Medical Education Seminar.

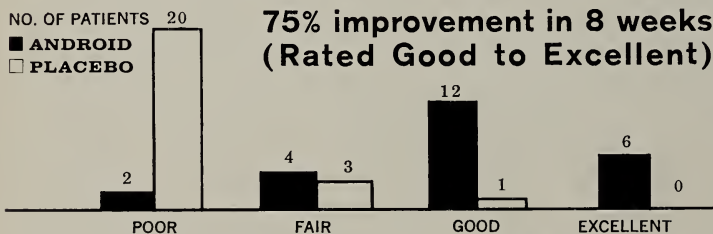
November 24 — Dermatology (tentative).

December 2-3 — Psychiatry Seminar.

Additional courses are pending and may be announced later. Details may be obtained from The Center for Continuing Medical Education, Ohio State University Medical Center, 320 W. Tenth Ave., Columbus 43210.

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- \* 1. *Treatment of Impotence with a Methyltestosterone-Thyroid Compound (Android)*, M. H. Dubin, *Western Medicine*, 5:67 Feb. 1964.  
2. *Methyltestosterone-Thyroid in Treating Impotence*, A. S. Titeff, *General Practice*, Vol. 25, No. 2, February, 1962, pp. 6-8.  
3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.  
4. Brochure Discussing Thyroid-Androgen Inter-relationship.



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Niacinamide . . . . .75 mg.  
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## Medical and Veterinary Doctors Join in Research at OSU

Ohio State University has received a comprehensive project grant of about \$1,500,000 from the U. S. Public Health Service for study of the biology of the heart.

The cooperative research effort between the Colleges of Medicine and Veterinary Medicine will be headed by James V. Warren, M. D., professor and chairman of medicine, and C. Roger Smith, D. V. M., professor and chairman of veterinary physiology and pharmacology.

Two broad areas of investigation will be explored over a seven-year period: (1) Cellular biology of the heart, and, (2) organ biology of the heart. In the cellular aspect, special attention will be directed to correlation between microstructure and function in cardiac physiology and pathology. Plans call for coordinated studies of structure by electron microscopy and the use of electrophysiologic technique, work performance and biochemical measurements in studying function.

Proposed areas of research include reaction of heart muscle to injury, biochemical control of energy released in the myocardium, and the maintenance of ion homeostasis in heart muscle.

The organ biology research will include studies in the comparative physiology of the heart, with particular emphasis on hemodynamics, electrophysiology, the genesis and nature of heart sounds and pharmacology as related to the cardiovascular system.

Members of the steering committee for the research project are: Robert L. Hamlin, D. V. M., College of Veterinary Medicine, and Robert C. Little, M. D., Arnold M. Weissler, M. D., Dante G. Scarpelli, M. D., and Fred A. Kruger, M. D., all of the College of Medicine.

Effective immediately, first-year funds from the grant will be used in part to renovate and equip working area for research in Sisson Hall.

## Nursing-Home Care Beds Included In Dayton VA Hospital

More than 1000 nursing-home care beds are scheduled to be in operation this summer in 27 Veterans Administration Hospitals, including one hospital in Ohio.

The new program was made possible by Congress under P. L. 88-450 enacted last year. The new law makes provision for an eventual 4,000 such beds for long-term veteran patients. This type of patient now comprises one-third of all VA hospital admissions, according to the VA announcement.

In Ohio, the Veterans Administration Hospital at Dayton will provide 30 such beds for the present. The program is expected to be in complete operation (4,000 beds for the nation) by June 30, 1967.

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

Location	Facility	Telephone
Akron	Children's Hospital W. Bowery and W. Bechtel	BL 3-5531, Ext. 246
Cincinnati	The Academy of Medicine of Cincinnati 320 Broadway	PA 1-2345
Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220

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# Scientific Section

VOL. 61

AUGUST, 1965

NO. 8

## Hypopituitarism Presenting as Hypoadrenotropism

### A Discussion of Two Interesting Cases

LEO STOLBACH, M.D., R. BENNETT EPPEs, M.D., FRANK STOCKDALE, M.D., Ph.D.,  
ROBERT MEHLER, M.D., and RALPH G. WIELAND, M.D.

THE finding of deficient ACTH secretion in patients with otherwise normal pituitaries has been infrequently reported.<sup>1,2</sup> Liddle described a group of patients with "limited pituitary reserve"<sup>3,4</sup> whose control urinary steroid excretion values were normal. However, many of these patients had pituitary tumors or had received therapeutic irradiation to the pituitary. In studies directed at evaluating the pituitary-adrenal axis, an adrenal response to administered ACTH was demonstrated in association with failure of the pituitary to respond to lowered circulating cortisol produced by Metopirone (SU-4885). In addition, these patients had shown clinical evidence of an inability to respond maximally to stress.

We recently studied two patients each of whom had shown an impaired response to the stress of a severe infection. Pituitary deficiency was not initially considered in either case because urinary steroids increased after ACTH administration, urinary gonadotropins were normal and the patients were clinically

#### *The Authors*

● Dr. Stolbach, Boston, Mass., former Resident in Medicine, University Hospitals of Cleveland, is now Research Physician at the Lemuel Shattuck Hospital, and Instructor in Medicine, Tufts University School of Medicine, in Boston.

● Dr. Eppes, Joliet, Illinois, former Assistant Resident in Medicine, University Hospitals of Cleveland, is now a Research Assistant on the staff of the Army Medical Research Project, University of Chicago, in Joliet.

● Dr. Stockdale, Bethesda, Maryland, former Intern in Medicine, University Hospitals of Cleveland, is now a Staff Associate at the National Institutes of Health, in Bethesda.

● Dr. Mehler, Cleveland, former Intern in Medicine and now Assistant Resident in Medicine, University Hospitals of Cleveland.

● Dr. Wieland, Columbus, former U.S.P.H.S. Research Fellow in Medicine, Western Reserve University School of Medicine, and Assistant Physician, University Hospitals of Cleveland, is now Assistant Professor of Medicine, Division of Endocrinology and Metabolism, The Ohio State University College of Medicine, and Assistant Director, OSU Clinical Research Center, Columbus.

From the Department of Medicine, Western Reserve University School of Medicine, and University Hospitals of Cleveland, Cleveland, Ohio. Submitted January 20, 1965.

Supported in part by the United States Public Health Service through training grant 2A-5293. Some studies were performed in the Clinical Research Center of University Hospitals, which is supported by grant FR 80-01 from the United States Public Health Service.

Reprint requests to Ralph Wieland, M.D., Ohio State University Hospitals, 410 West 10th Avenue, Columbus, Ohio 43210.

euthyroid. However, further evaluation revealed a failure to respond to Metopirone suggesting an impairment in ACTH production as the primary manifestation of hypopituitarism. Metopirone, by blocking 11-hydroxylation, the last step in cortisol synthesis stimulates endogenous ACTH release through the negative feedback mechanism. If the pituitary-adrenal axis is intact there will be an increased secretion of 11-deoxycortisol reflected by an increase in urinary 17-hydroxycorticosteroids. The following report emphasizes the importance of the Metopirone test in patients who respond poorly to stress but whose control plasma and urinary steroids may be normal or only slightly below normal.

Methods and Materials

Plasma and urinary 17-hydroxycorticosteroids (17-OHCS) were measured by the modified Porter-Silber reaction.<sup>5</sup> Normal values for our laboratory are 4 to 12 mg/24 hours for urinary 17-OHCS, and 5 to 25 mcg/100 ml plasma for plasma 17-OHCS drawn at 8:00 a.m. Creatinine determinations were performed on all urines to check the completeness of collection. Response to ACTH was measured by an eight hour infusion of 40 units of ACTH on three consecutive days. The Metopirone test consisted of the administration of oral Metopirone 750 mg every four hours for six doses with the response being considered normal if the urinary 17-OHCS were twice the control value and in excess of 15 mg/24 hours on the day of Metopirone administration or the day following.<sup>3,6</sup> Serum growth hormone was measured\* in the fasting state and again 90 minutes after injection of regular insulin, 0.1 unit/kg body weight, using a modification of the method of Dominguez and Pearson.<sup>7</sup>

Case Reports

**Case 1.** A 54 year old Negro man with known obstructive emphysema and cor pulmonale was admitted to University Hospitals in 1962 with acute bronchopneumonia and severe hypotension. The hypotension responded poorly to large amounts of norepinephrine but did respond to the intravenous administration of 100 mg of hydrocortisone sodium succinate (Solu-Cortef<sup>®</sup>). Maintenance hydrocortisone was gradually reduced and finally discontinued on the sixth hospital day. Three days later control urinary 17-OHCS were 3.5 mg/24 hours with an increase to 8.9 mg/24 hours following a single eight hour infusion of 40 units of ACTH. Because of the definite response to ACTH and no other evidence of anterior pituitary dysfunction, a diagnosis of pituitary insufficiency or Addison's disease was not made, and consequently cortisol replacement was not given at the time of discharge.

The patient was readmitted in August 1963 because of increasing shortness of breath and weakness. He denied any change in libido. Examination revealed a blood pressure of 130/70. Other than signs consistent with emphysema and probable chronic gouty arthritis manifested by shoulder involvement and a uric acid of 9.4 mg/100 ml, pertinent findings included normal testes, prostate, and body hair distribution. The visual fields were intact. During this admission he became febrile for a 72 hour period with acute sinusitis, and as shown in Table 1 responded with a slight increase in urinary 17-OHCS.

The patient's blood urea nitrogen and serum sodium, potassium, and chloride were normal. Liver function tests,

including a bromsulphalein retention of 4 per cent, were normal. Endocrinologic studies listed in Tables 1 and 2 show evidence for diminished adrenal cortical secretion during control periods and in response to Metopirone. Skull x-rays were normal.

**Comment:** Inadequate cortisol production was indicated by the low control plasma and urinary 17-OHCS, the flat oral glucose tolerance test, and the abnormal water loading test. The value of 11.4 mg/24 hours for urinary 17-OHCS, while the patient was receiving 60 mg/day of oral cortisol, ruled out abnormal pathways of peripheral metabolism of cortisol as the basis for the patient's low control levels. Exogenous ACTH increased steroid production and corrected the abnormal water loading test. Recent work by Liddle *et al.*<sup>8</sup> has shown that the negative feedback mechanism of the pituitary adrenocortical system is not the only regulator of pituitary ACTH production and that stress is an additional factor causing corticotropin release.

Patients who are unresponsive to Metopirone have been shown to be capable of responding to surgical trauma.<sup>4</sup> It is therefore not surprising that this patient had an occasional normal control value for urinary excretion of 17-OHCS (table 1) and an increase in urinary 17-OHCS with acute sinusitis (table 1). Indeed, under daily living conditions this patient

TABLE 1. Urinary and Plasma Steroids

	Urinary 17-OHCS in mg/24 hours	
	Case 1	Case 2
Control .....	1.6	0.6
Control .....	4.5	1.0
ACTH		
1st day 40 units I.V. over 8 hours	8.3	3.8
2nd day 40 units I.V. over 8 hours	10.7	6.1
3rd day 40 units I.V. over 8 hours	15.0	8.0
2 days post ACTH .....	2.6	—
Acute sinusitis, febrile .....	7.5	—
Control .....	1.4	1.2
Metopirone 750 mg q4h x 6 .....	4.8	2.6
Day after Metopirone .....	3.1	1.3
Cortisol 60 mg/day orally .....	11.4	—
Plasma 17-OHCS in $\mu$ g/100 ml		
	Case 1	Case 2
Control .....	2.0 and 3.2	9.8

did not develop the classical stigmata of adrenal insufficiency. Wieland and co-workers<sup>9</sup> have measured Porter-Silber chromogens in the adrenal venous effluent of normal males and suggested that under basal circumstances the rate of cortisol secretion, and presumably therefore of corticotropin, may be quite small. However, in this patient it seems apparent that the ACTH response was not adequate for the more severe stress of pneumonitis. The failure to show a significant increase in urinary 17-OHCS following Metopirone administration would seem to confirm this.

The patient was treated with cortisone acetate 12.5 mg every eight hours with subsequent improvement in his feeling of weakness and fatigue which had initially been attributed to his respiratory disease.

**Case 2.** A 47 year old Negro woman was admitted to University Hospitals on January 23, 1964, with paroxysmal

\*The growth hormone measurements were kindly performed by Dr. Olaf H. Pearson.



TABLE 2. *Other Tests of Anterior Pituitary Function*

Test	Case 1	Case 2
Urinary gonadotropins (normal 8-64 mouse units/24 hours) .....	8 mouse units	32 mouse units
PBI (normal 4-18 $\mu$ g/100 ml) .....	3.1 $\mu$ g/100 ml	3.1 $\mu$ g/100 ml
PBI 24 hours after 5 U of TSH .....	6.1 $\mu$ g/100 ml	6.4 $\mu$ g/100 ml
PBI 10 days after TSH .....	3.4 $\mu$ g/100 ml	
<sup>131</sup> I 24 hour uptake (normal 15% - 45%) .....	24%	16%
<sup>131</sup> I 3 hour pre-TSH (normal 5%-20%) .....	7%	7%
<sup>131</sup> I 3 hour post-TSH (normal 10% more than 3 hour pre-TSH) ....	25%	19%
Ta- <sup>131</sup> I resin sponge uptake (normal 80%-120%) .....	133%	88.4%
Skull x-rays .....	Normal sella turcica	Normal sella turcica
Growth hormone		
Fasting (normal 0*-0.5 $\mu$ g/100 ml) .....	0.24 $\mu$ g/100 ml	0
30 minutes after IV insulin .....	0.48 $\mu$ g/100 ml	
90 minutes after IV insulin .....	1.24 $\mu$ g/100 ml	0.48 $\mu$ g/100 ml
Water loading test		
Control .....	abnormal	abnormal
Cortisol 100 mg IM 3 hours before test .....	normal	
After ACTH (25 U IM q12h for 4 doses) .....	normal	
ACTH 40 U IV during test .....		improved but still below normal
Glucose tolerance test .....	F 83; ½ hr 82; 1 hr 90; 2 hr 60	

\*Approximately 10% of normals tested have had no detectable fasting growth hormone activity. The growth hormone response to hypoglycemia is normal.

atrial tachycardia, which spontaneously converted to regular sinus rhythm. She gave a history of increasing fatigability and of loss of pubic and axillary hair during the previous four and one-half years. Aside from fatigue, there were no symptoms suggestive of hypothyroidism. Spontaneous menopause had occurred four years previously.

In 1960 when she was admitted with aseptic meningitis, her blood pressure was 90/65. She developed hyponatremia with a serum sodium of 126 mEq/L, which returned to normal prior to discharge. Urinary 17-ketosteroids varied from 1.2 to 2.5 mg/24 hours and rose to 6.6 mg/24 hours on the second day of ACTH stimulation. A chest x-ray revealed hilar adenopathy with upper lobe scarring and retraction. An electrocardiogram showed diffuse T wave inversion. Tuberculin and Kveim skin tests were negative. She subsequently acquired a rash on the hands, which biopsy proved to be psoriasis. In July 1963, she developed pneumonia, which responded to penicillin. During that illness she experienced a syncopal episode.

At the time of her present admission, her systolic blood pressure was 70, but after conversion to regular sinus rhythm her blood pressure averaged 110/70. Laboratory findings included normal serum sodium, potassium, and chloride, and normal blood urea nitrogen. Two determinations of serum uric acid were 9.8 and 5.0 mg/100 ml. Liver function tests were normal except for a mildly elevated bromsulphalein retention of 10 per cent. A chest x-ray again revealed fibrosis, and an electrocardiogram, after conversion to regular sinus rhythm, showed persistent diffuse T wave inversion. X-ray of the skull showed a normal sella turcica. Protein electrophoresis showed an elevated gamma globulin of 25 per cent. A scalene node biopsy revealed hyperplasia and a liver biopsy showed mild focal subacute periportal inflammation.

Endocrinologic studies listed in Tables 1 and 2 show an ability to respond to exogenous ACTH but not to Metopirone.

**Comment:** Although a positive tissue diagnosis was not obtained, the pulmonary, cardiac, and hepatic findings and the elevated gamma globulin make a diagnosis of sarcoidosis likely. Sarcoidosis is known occasionally to involve the pituitary, most frequently producing diabetes insipidus or panhypopituitarism.<sup>10</sup> It is possible that this patient may eventually show the other clinical manifestations of panhypopituitarism (her borderline low protein bound iodine [PBI] and low normal radioiodine [RAI] uptake values suggest that this may actually be the case, although the clinical stigmata of hypothyroidism are absent). However, at

present a pituitary deficiency of ACTH production seems best to explain this patient's major clinical and laboratory findings.

The response to ACTH was sluggish but definite, ruling out primary adrenal insufficiency. The patient's mild hepatic disease is not sufficient to explain the low control values for the urinary steroids.<sup>11</sup> She was treated with cortisone acetate 12.5 mg every eight hours with marked reduction of fatigue, a 4 kg weight gain in seven weeks, and the regrowth of her pubic and axillary hair. It is unlikely that the symptomatic improvement can be attributed to the use of replacement doses of cortisone on the basic disease since the dose is small and the presumed sarcoid process shows little if any current activity.

### Discussion

When investigating the cause for low urinary steroid values, one must exclude frank hypothyroidism,<sup>12</sup> severe liver disease,<sup>11</sup> or ingestion of drugs such as diphenylhydantoin,<sup>13</sup> triparanol,<sup>14</sup> or o-p'DDD,<sup>15</sup> which alter the usual pathways of steroid metabolism. These factors were carefully excluded in our patients.

Both patients had lower than normal values for PBI. In Case 1, this finding could best be explained as resulting from a low level of thyroid binding globulin.<sup>16</sup> This assumption is suggested by the elevated T<sub>3</sub> <sup>131</sup>I resin sponge uptake accompanied by the normal values for <sup>131</sup>I uptake, normal response to thyroid stimulating hormone, and lack of clinical evidence for hypothyroidism. Case 2 showed no clinical evidence of hypothyroidism. However, the borderline low values for PBI and RAI uptake in this patient may be early evidence for a pituitary defect in the production of thyrotropin.

Further confirmatory evidence for a relative ACTH deficiency in our patients is the normal water loading test after ACTH in Case I and improvement in the response in Case 2.

Both of our cases, we feel, demonstrate the

deficiency of tropic stimulation of the adrenal resulting from a pituitary defect of ACTH production. Measurement of a low circulating level of ACTH would have confirmed the diagnosis. However, current techniques are not sensitive enough to differentiate unequivocally between normal and low plasma levels.<sup>4</sup>

Hypothalamic pituitary regulation of ACTH secretion has recently been reviewed.<sup>17</sup> Whether the defect in these patients represents a chemical or a structural acquired lesion in either of these centers is conjectural. We were unable to demonstrate a gross lesion in either case by skull x-rays, though in the patient with suspected sarcoid a microscopic lesion could exist which may eventually produce additional manifestations of hypopituitarism. A deficiency of ACTH production is usually not the first tropic defect to become clinically apparent in patients who subsequently are shown to have hypopituitarism. This emphasizes the importance of suspecting a deficiency of ACTH production in patients who respond poorly to stress even when the evidence for other tropic defects is slight or not apparent.

Baseline steroids may be low or normal. A further clue may be provided by a sluggish response to ACTH. Confirmation of the diagnosis is obtained by the lack of adrenal response to a Metopirone test. Although a false response to this test may occur, it is considered the most sensitive test available for the detection of a deficiency in the secretion of ACTH.<sup>3</sup>

**Acknowledgment:** The authors wish to acknowledge the assistance and advice of Drs. George J. Hamwi, Olaf H. Pearson, and Max Miller.

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**A**CCIDENTAL POISONING in children with digitalis is not a common event, but the consequences are sufficiently dangerous that patients or parents of patients who take digitalis regularly should be acquainted with the various ways in which children can be poisoned. Poisoning may occur by ingestion of digitalis from a bottle in the medicine cabinet, or a playmate may feed another child digitalis. Errors in dispensing or ordering are important causes. Ingestion of certain plants can be fatal. The physician treating the expectant mother with digitalis should exercise great caution.

Electrocardiographic signs of digitalis effect do not require specific drug treatment and differentiation from digitalis toxicity is necessary.

Treatment is symptomatic and always dependent upon severity of symptoms and changes in the electrocardiogram. A guide for therapy that is generally related to changes in the electrocardiogram as well as the clinical state of the patient is presented. Intravenous potassium therapy has been incorrectly emphasized in the past as a general measure of therapy. Depression of the cardiac-conduction system and myocardium by this measure precludes the routine use of potassium in the therapy of digitalis toxicity. — Dan G. McNamara, M.D., Earl J. Brewer, Jr., M.D., and George D. Ferry, M.D., Houston, Texas: *The New England Journal of Medicine*, 271:1106-1108, November 19, 1964.



# The Radio-Rose Bengal Hepatogram

## A Practical Technic in Distinguishing Types of Jaundice

LOWELL C. MECKLER, M. D.

IN 1923 Delprat demonstrated that Rose Bengal (tetraiodotetrachlorofluorescein) was quantitatively excreted by the liver in the bile.<sup>1,2,3</sup> He also showed that complete extrahepatic obstruction will cause the dye to be retained in the blood stream. Very little experimental work was done in the following years until 1955 when Sapirstein and Simpson<sup>4</sup> reported that there was insignificant clearance by the kidneys. Skin, lungs, and other organs were studied with various concentrations of Rose Bengal and only the liver and gallbladder were colored by the dye. Taplin<sup>5</sup> and others in the same year, using rabbits, studied the effects of a hundredfold increase in serum bilirubin on the mechanics of Rose Bengal excretion by the liver and possible gastrointestinal uptake of the dye during the time it was eliminated from the body. They concluded that a substantial increase in concentration of the serum bilirubin did not alter the excretory pathway of the dye and there was no appreciable uptake via the gastrointestinal tract.

Taplin et al.<sup>5</sup> were the first to report the use of tagged ( $I^{131}$ ) Rose Bengal in their studies and they outlined a technic for its use in the differential diagnosis of jaundice. In the past eight years, numerous articles have appeared demonstrating variations and suggesting innovations of liver function studies with the use of Radio-Rose Bengal hepatogram. It is the purpose of this paper to determine the reliability of Radio-Rose Bengal (RBI<sup>131</sup>) as a laboratory aid in the differential diagnosis of jaundice and to develop a practical laboratory test with reproducible results.

### Materials and Methods

Eighty-four tests were run in a nine month period on patients at the Mount Carmel Hospital. In an effort to standardize the dosage of RBI<sup>131</sup> in adults, several test doses were evaluated to determine the minimal optimum dose in normal subjects. These consisted of 5, 7.5, 10, 15 and 20 microcuries of RBI<sup>131</sup>. Although the 5 microcuries dose did not give a five minute counting rate over 10 times that of the background count, as suggested by Blahd,<sup>6</sup> it had the advantage of shortening the peak time in those patients with severe parenchymal and obstructive disease without losing the sensitivity of the testing procedure. Using less than 5 microcuries per test

### The Author

● Dr. Meckler, Columbus, is Resident in Medicine, Mount Carmel Hospital.

dose caused the values to overlap in normal subjects and in those patients with only moderate dysfunction states, and there did not appear to be any advantage in distinguishing hepatocellular from obstructive jaundice. The only calculation in which a dose of 5 microcuries was insufficient was in the determination of liver vascular capacity, a value deemed not absolutely necessary to aid in distinguishing types of jaundice.

The patients were divided into four groups:

	Total	Jaundiced
1. Normals (no liver disease) .....	41	0
2. Primary liver parenchymal cell disease	19	16
3. Extrahepatic obstructive disease .....	10	10
4. Intrahepatic obstructive disease .....	8	8
5. Miscellaneous .....	6	2

Group 5 included the following: one patient with pancreatic fibrocystic disease, one patient with amyloidosis, one patient with metastatic carcinoma to the gallbladder, and three patients with carcinomatous liver metastasis, two of whom were jaundiced. The final diagnoses were determined by liver biopsy, correlating liver function studies, clinical course, surgery or postmortem examination. The adjunct liver function tests included Bromsulphalein®, where practical, serum glutamic oxaloacetic transaminase, alkaline phosphatase, cephalin flocculation, Van den Berg, and prothrombin time. A tissue examination was made in 33 of the 36 cases of jaundice tested.

### Procedure

The patient is brought to the radioisotope testing laboratory in a fasting state, and placed in a supine position on the table. The intended counting areas over the head and liver are determined and the liver area marked with an indelible pencil.

One probe of a Picker Dual Ratemeter\* (lead collimated counter with the 3 inch sodium iodide crystal 6 inches from the surface) is placed on the right an-

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\*The equipment used in this work consisted of a Picker Dual Ratemeter (Model 600-046); Twin-mast Mobile Probe Stand (#1376); Scintillation Probes (#2801); Scintillation Well Counter, Transitorized (#2804); Clinical Analyzer (#5802); and the Mag-nascaler II (#600501).

terolateral aspect of the chest wall and directed away from the gallbladder in the manner of Taplin et al.<sup>7,8</sup> The other probe is positioned at the lateral aspect of the head, the midpoint being the left ear (Fig. 1). The ratemeter for the liver probe is set to register a range of 1,000 counts per minute. A 30 second time constant is used to obtain a smooth curve. The



FIGURE 1

background count is taken for a three minute period. The graph speed is 6 inches per hour.

Rose Bengal I<sup>131</sup> is injected intravenously in the right antecubital vein as quickly as possible. The exact time is noted and the graph paper marked accordingly. The dose is 5 microcuries RBI<sup>131</sup>, previously counted by the liver probe of the Picker Dual Ratemeter at a set distance of 2 inches, in a carrier 5.0 mg. nonradioactive Rose Bengal.

The Picker Dual Ratemeter gives continuous counts and allows a permanent recording to be made for both the liver and head probes. The count over the head is noted at 5 and again at 20 minutes. Two ml. of blood are withdrawn from the left antecubital vein at 10 minutes and again at peak, to be counted in the scintillation well counter. One ml. of blood is carefully pipetted into a standard glass counting tube, placed in the scintillation well counter and its radioactivity is measured for 10 minutes. The resultant one minute average count is then determined. The liver uptake peak is defined as the initial portion of the liver curve which reaches a stable plateau for five minutes.

If the patient is jaundiced, the continuous recording is stopped when peak liver activity is reached, the two probes readjusted so that one is over the gallbladder area (placed perpendicularly by noting the point of highest activity) and the other probe is placed just below the umbilicus directed 30° toward the feet. Five ml. of sodium dehydrocholate is then injected intravenously and 0.6 mg. of nitroglycerin is placed sublingually. The counts are

recorded continuously for another 20 minutes. If needed, the nitroglycerin is repeated in 10 minutes. It has been previously noted that the combined use of sodium dehydrocholate and nitroglycerin is superior to ingestion of homogenized milk or intravenous injection of cholecystokinin. The sodium dehydrocholate temporarily increases bile flow 5 to 10 times its normal rate and the nitroglycerin insures relaxation of the sphincter of Oddi.<sup>7,12</sup>

The count over the liver is repeated in 24 hours and 2 ml. of blood are again withdrawn from the left antecubital vein, for counting in the scintillation well counter. The liver count is taken over the initial site as previously marked.

From the foregoing data, the following calculations are made:

- a. Time of peak liver activity in minutes.
- b. Percentage of RBI<sup>131</sup> retention = 
$$\frac{20 \text{ minute blood count} \times 100.}{5 \text{ minute blood count}}$$
- c. Corrected liver uptake factor (L. U.) = 
$$300 - \left( \frac{\text{peak blood count} \times 300}{10 \text{ minute blood count}} \right) \text{ peak time}$$
- d. Liver excretion percentage (L. E.) = 
$$\frac{24 \text{ hour liver count} \times 100}{\text{peak liver count}}$$
- e. Blood clearance percentage = 
$$\frac{24 \text{ hour blood count} \times 100}{\text{peak blood count}}$$

### Results

There was a marked difference in the curves of the normal versus the abnormal hepatogram. The information obtained from the graphs and blood counts shows the rapid increase of the liver uptake and corresponding decrease of the dye from the blood stream in the normal patient. The peak liver uptake in normal patients in this series was always less than 30 minutes and the 20 minute to 5 minute ratio of blood clearance ranged from 27 to 50 per cent. The steep decrease in the blood counting rate is characteristic of normal RBI<sup>131</sup> clearance, while a slower decrease is seen in abnormal liver function states and yields values in excess of 50 per cent in the 20 minute to 5 minute ratio. In the conditions of abnormal liver function states it required more than 30 minutes to reach peak liver uptake (Graphs 1, 2).

The other calculations made from the graph and counts were the corrected liver uptake factor (L. U.), the liver excretion percentage (L. E.), and the percentage of dye remaining in the blood at 24 hours. The normal subjects were found to average about 300 counts per minute at the 10 minute baseline count as determined by placing 1 ml. of blood in the scintillation well counter. As the exact dosage varied slightly from patient to patient despite attempts to standardize the test dose in counts per minute, the

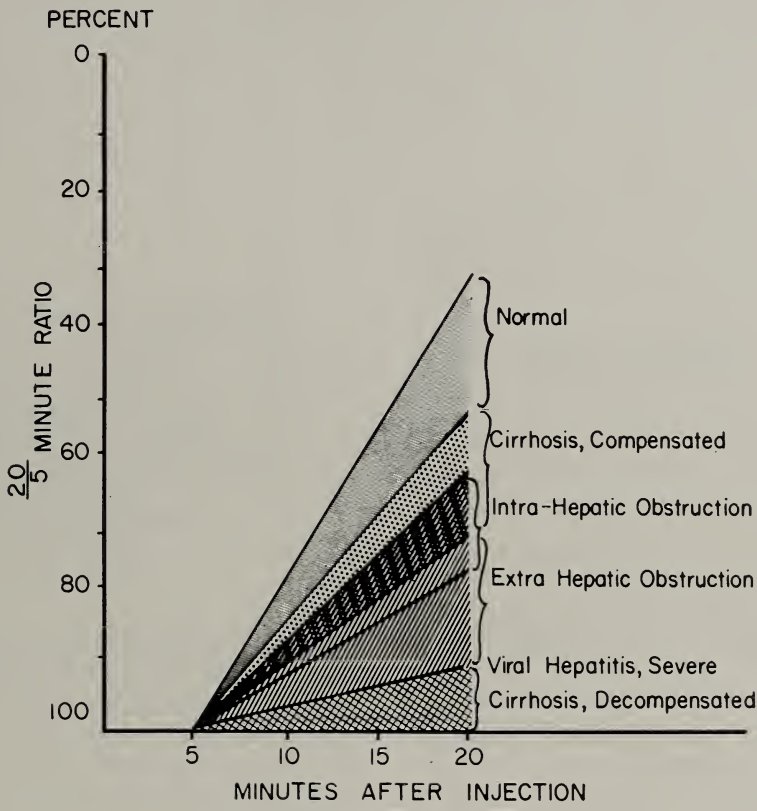


calculation for the liver uptake (L.U.) was determined by using 300 counts per minute as the "normal" baseline. The corrected liver uptake levels in normal patients fell between 8 and 12. The liver excretion percentage reflects the ability of the liver parenchymal cells to excrete the dye into the biliary system and was determined by the amount of net radioactivity over the liver at 24 hours as compared

dominal count. Patients with complete extrahepatic obstruction demonstrated no increase in the amount of radioactivity entering the intestine. In this manner, extrahepatic biliary obstruction was localized (Graph 3).

There were 36 jaundiced patients studied, and the diagnosis was well documented in all cases, including liver biopsy specimens in 33 patients. The sta-

**BLOOD CLEARANCE RANGES**  
NORMAL & VARIOUS DISEASES



GRAPH 1

to the peak level. Similarly, the amount of radioactivity remaining in the blood at 24 hours as compared to the peak value reflects on the liver's capacity to take up the dye from the blood stream.

Those patients who were jaundiced were further examined as to the patency of the biliary tract by stimulating the gallbladder to contract in the manner described by Kawaguchi, Berk and Soble,<sup>12</sup> using sodium dehydrocholate and nitroglycerin.

In patients with patent biliary ducts, a marked increase in radioactivity under the abdominal probe and a corresponding decrease in the amount of radioactivity under the gallbladder probe was recorded. Patients with partial common bile duct obstruction developed a slight to moderate increase in the ab-

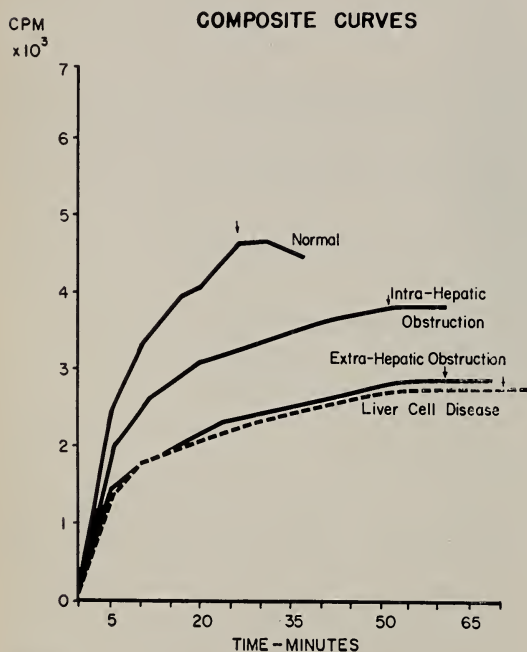
dominal count. Patients with complete extrahepatic obstruction demonstrated no increase in the amount of radioactivity entering the intestine. In this manner, extrahepatic biliary obstruction was localized (Graph 3).

Primary liver parenchymal disease .....	16
a. Hepatitis .....	2
b. Cirrhosis (without coma or ascites)....	12
c. Cirrhosis (with coma or ascites) .....	2
Extrahepatic obstructive disease .....	10
a. Complete .....	8
b. Partial .....	2
Intrahepatic obstructive disease .....	8
a. Cholangiolitis .....	7
b. Thorazine jaundice .....	1
Carcinomatous metastases to the liver .....	2

In the 12 cases of compensated cirrhosis, the 20 minute to 5 minute blood disappearance ratio corres-

pounded in direct proportion to the total amount of serum bilirubin, i.e., the higher the serum bilirubin, the greater the ratio percentage. The corrected liver uptake value (L.U.) was between 4 and 5 in all cases, higher values occurring in patients with the less severe cirrhosis. The two cases of acute hepatitis showed L.U. values near 4.0 and both had rather high 20 minute to 5 minute ratios, around 80 per cent. There were no apparent relationships between the Radio-Rose Bengal hepatogram values and the serum glutamic oxaloacetic transaminase determination. The Bromsulphalein test and the RBI<sup>131</sup> values were compared in all the cases with primary hepatocellular disease and no correlation could be found. The two cases of decompensated cirrhosis in hepatic coma had very little clearing of the dye from the bloodstream at 20 minutes and consequently they recorded the lowest L.U. values.

Eight of the 10 patients with extrahepatic obstructive disease had tumors and the remaining two had common duct calculi. The L.U. values for this group fell between 2 and 4 and did not appear to reflect the total serum bilirubin but rather were more in



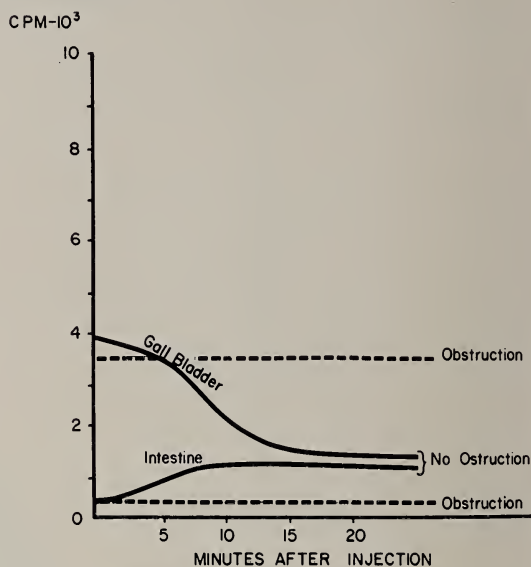
GRAPH 2

accord with the alkaline phosphatase. The eight cases that were considered as total obstruction had L.E. values greater than 60 per cent, while one of the patients with partial obstruction (common duct stone) had only 32 per cent of peak activity remaining over the liver at 24 hours. Both partial obstruction cases had low blood levels at 24 hours, less than 20 per

cent peak activity, while the complete obstruction patients had greater than 25 per cent peak activity.

The patients with intrahepatic obstruction numbered eight, seven with cholangiolitis and one with chlorpromazine jaundice. The graphs and values for this group have a mixed pattern of obstruction and hepatocellular damage; the L.U. values are between

## ABDOMINAL COUNTING TECHNIQUE



GRAPH 3

3 and 6, with five patients in the 4 to 5 range. There appeared to be no correlation with any of the laboratory work. Indeed, without liver biopsy, this type of hepatic disturbance seemed to be the most difficult to diagnose. The L.E. percentage was variable, but the 24 hour blood activity was greater than 25 per cent. The 20 minute to 5 minute ratios were between 60 and 80.

The last two jaundiced patients had biopsy confirmed metastatic neoplasia from the primary sources of lung and ovary. Both patients were mildly icteric clinically, and their Radio-Rose Bengal tests are indicative of liver cell damage.

The radioactive hepatograms in this series were run on a random group of clinically jaundiced hospital patients and corresponding number of normal controls over a nine month period. This study was intended to determine if a practical and accurate diagnostic laboratory aid could be evolved that would be of benefit to the clinician in helping him to diagnose difficult cases of jaundice. Although the results reported in this paper are very encouraging, there is some overlap of values and it is hoped that



serial testing may provide more information (Chart 1).

Discussion

Rose Bengal I<sup>131</sup> is incorporated into the "battery" of liver function tests. As there is no all inclusive laboratory test that is accurate and yields reproducible results at this time, attention has been focused on the radioactive compounds to evaluate the efficacy of their use in determining the functional activity of the liver and the gallbladder as well as the patency of the common bile duct. Many

at 24 hours over the background radioactive count. This very slight increase in radioactivity was interpreted as an expression of the vascularity of the gland as well as minimal iodide uptake.<sup>15,16</sup> RBI<sup>131</sup> has the further advantage in that the small amounts which are used can be given to jaundiced patients, as there are no known reactions from the dye and the test does not involve a colorimetric end-point.

After RBI<sup>131</sup> enters the bloodstream, it is quantitatively cleared by the liver parenchymal cells and is excreted in the bile. The rate of blood clearance is

CHART 1. Results of Radioactive Hepatogram in Normal and Jaundiced Patients

Category	Liver Uptake	Liver Excretion	$\frac{20}{5}$	24 Hour Blood	Time in Minutes
Normal.....	8-12	< 20%	< 50%	< 30%	< 30 min.
Liver Cell Disease.....	4-5	< 60%	> 50%	< 30%	> 30 min.
Obstructive Disease.....	2-4	C. > 60% P. 30-60%	> 50%	C. > 25% P. < 20%	> 30 min. > 50 min.
Cholangitis.....	3-6	< 60%	> 50%	> 25%	> 30 min.
Hepatic Coma .....	2-2.5	> 60%	> 90%	< 20%	> 30 min.
C. Complete P. Partial					

papers have been written describing the results of various techniques of evaluating hepatic function using Radio-Rose Bengal. By comparing the various procedures as to difficulty in the mechanics of doing the test, patient discomfort, time, economic factors of the procedure, and the significance of interpretation, many of the previously reported procedures seemed cumbersome and not easily adaptable for clinical use. The method presented here is easy to use, and the determinations involve a minimum of calculations.

The liver polygonal cells lie between the sinusoidal blood spaces and the submicroscopic biliary canaliculi and have many functions, including the formation of bile. It is in the polygonal cells that cholic and deoxycholic acids are conjugated with taurine and glycerin, bound to albumin, and transported into the biliary ducts by an active transfer system. Bromsulphalein and Rose Bengal are handled by mechanisms resembling those used for the transfer of bilirubin.<sup>36</sup> Bromsulphalein is conjugated with glutathione in the polygonal cells, but Rose Bengal can be excreted into the biliary system without conjugation. Rose Bengal, which is made radioactive by exchange resins, is stored in the gallbladder during the fasting state and evacuated into the intestine with bile on stimulation of the gallbladder to contract.<sup>13,14</sup> The dye is not reabsorbed from the intestine and, in the several normal patients who collected stools following the test, 80 to 85 per cent of the radioactivity was excreted within 48 hours.

The thyroid gland was routinely scanned also in the patients in this series, to determine the increase, if any, in radioactivity of the gland. In no instance did a repeat scanning yield more than a 1 per cent increase

a function of the activity of the polygonal cells, the hepatic blood flow, and the patency of the biliary ducts. Any abnormality of one or more of these will change the uptake and/or excretion values. In acute hepatitis, the polygonal cells are chiefly involved, while in cirrhosis, the fibrotic changes reduce the blood flow through the liver and parenchymal damage occurs late. Obstruction of the biliary ducts initially may occur without liver cell involvement, but the parenchymal cells will become secondarily affected if the obstruction is not relieved.

The simplified continuous counting method outlined in this paper confirms the results of other workers regarding the 20 minute to 5 minute blood ratio. When this ratio is over 90 per cent, primary intrahepatic jaundice is present. Nordyke and Blahd<sup>17-20</sup> inject 10 to 25 microcuries of RBI<sup>131</sup> and obtain serial blood counts every two minutes for 20 minutes. As there is much overlap in the values obtained, they recommend this procedure be used to follow the course of acute or chronic liver disease. Another method yielding similar values involves multiple venipunctures over a 40 minute period.<sup>21</sup>

The technic of determining biliary tract obstruction described in this paper is easy to perform and has a relatively distinct end-point. There are no calculations involved. Other authors plot blood disappearances of the dye and calculate intestinal entry on semilogarithmic paper at five minute intervals using curves that are geometrically displaced to give a common starting point of 100 counts per minute at five minutes after injection.<sup>9-11</sup> Milk or cholecystokinin is used, and the entire procedure requires the patient to be supine without moving for 90 minutes, and involves the continuous precise place-

ment of the counting probes at predetermined sites. The inaccuracy of this method involves the application of the probes on the exact spot every time and at the same angle as before. The physician supervising this procedure must stay with the patient and be constantly moving probes during this time.

Normally, the abdominal curve will parallel the head curve for about 15 minutes after injection because both are indicating blood radioactivity. But as the liver excretes the dye into the intestine, the curves separate and the abdominal counts will increase and the head counts will continue to decrease. Stimulation of the gallbladder to contract will accentuate this difference in the curves. In extrahepatic obstruction, little or no dye will be excreted into the intestine and the curves will be similar. Intrahepatic obstructions show flat curves with poor clearance of RBI<sup>131</sup> from the blood but have some separation of the curves of gallbladder stimulation.

As the entire initial testing procedure outlined in this paper usually lasts one hour, other laboratory or radiologic procedures may be done in the morning and the patient brought to the radioisotope laboratory in the afternoon. Multiple readings over the liver and head, before the 24 hour readings, do not increase the accuracy of the test, but instead allow for even more errors to be made.

By previous comparison with RISA®, Kawaguchi et al.<sup>22</sup> and Taplin<sup>7</sup> found that the radioactivity over the liver in the first one to two minutes of the Radio-Rose Bengal test can be used to measure the vascular capacity of the liver. Therefore, the amount of radioactivity within 30 to 90 seconds after injection, before the polygonal cells take up the dye, is a measure of liver vascularity. This is expressed as a percentage of the injected radioactivity. Although patients with cirrhosis have a reduced liver vascular capacity as compared with patients having hepatitis, Taplin<sup>8</sup> was unable to differentiate these two groups on this basis, due to overlapping of the values.

As others have previously reported,<sup>7, 23-25</sup> comparison of the biochemical laboratory tests with the radioactive hepatogram disclosed the latter to follow more closely the clinical course of the disease. No attempt was made in this paper to graph the differences between the adjunct liver tests and the radioactive hepatogram. In the cases in this series, the RBI<sup>131</sup> test disclosed whether the disease process was extrahepatic or intrahepatic either before the biochemical tests or when the laboratory tests were confusing in nature. With the use of the outlined criteria, even early cirrhotic changes were detected.

Brown et al.<sup>26</sup> compared blood counts at specific intervals from 15 minutes to 24 hours and reported inconclusive results from this study. Lowenstein<sup>27, 35</sup> calculated excretion half-time and uptake half-time and compared these values to hepatic blood volume. Although his standard deviation was  $\pm 25$  per cent, he concluded that the results were characteristic of

the various liver diseases. Cohn et al.<sup>28</sup> found different activity peaks over the liver but noted normal patients returned to baseline activity, i.e. 3 minutes after injection, within two hours.

Moertel and Owen<sup>29</sup> compared Bromsulphalein and RBI<sup>131</sup> in nonjaundiced patients and found Bromsulphalein to be more sensitive. Mena et al.<sup>30</sup> conceived the idea of a "stress" dose of Bromsulphalein, 2.5 mg/kg., to reduce blood clearance of RBI<sup>131</sup> in patients with hepatic disease. However, increasing the dosage tends to make normal patients have abnormal RBI<sup>131</sup> hepatograms.

Others have used 5 microcurie doses of RBI<sup>131</sup> with varying success. Lum's group<sup>24</sup> reported poor correlation of biochemical laboratory tests with the radioactive hepatogram, the same findings noted earlier in this paper. This group also reported a plan to differentiate between hepatitis, calculus, cirrhosis, and carcinoma by means of computing blood counts and liver uptake figures at peak and again at 24 hours.<sup>23</sup> Although the testing pattern of the present study was similar to that of Lum et al., no such differentiation could be made. Since there is secondary hepatocellular damage in obstructive disease, this fact apparently invalidates most calculations.

Cohn<sup>28</sup> has pointed out many of the differences attendant in the use of the Radio-Rose Bengal test. The main source of error lies in application of the collimated lead probes, for a slightly different position or angulation would change the recorded values. Therefore, it is imperative that the procedure be run under the strict supervision of a well-trained technician. By using a small dose, 5 microcuries, the time required for the patient to lie quietly is reduced. The procedure as outlined in this paper permits the physician to allow a technician to complete the testing after the initial placement of probes and injection of the dye.

Another feature of this test that makes it difficult to interpret is the variance of end-points in actual counts per minute. The liver either handles the dye differently as influenced by the state of nutrition, variable hepatic blood flow in normal individuals, or other, yet unrecognized, conditions. Small variations of dosage, even in normal patients, may cause distinguishable differences in their hepatograms.

Instead of attempting to report results in actual counts, it was felt that percentage values would be more meaningful and would tend to cancel out errors that might be caused by administration of the dye or calculation of the actual dosage. Indeed, it was observed that, if by chance some of the dye were to extravasate into the tissues surrounding the vein, a normal person would have an abnormal tracing. This happened twice to volunteers in our series, but repeat RBI<sup>131</sup> test several days later showed typical normal curves. Therefore, it is important that the venipuncture be made properly.

There is some indication in this series, and in other



papers that were reviewed that early diagnosis of decreased hepatic function due to cirrhosis might be possible by noting low normal or slightly abnormal results using the RBI<sup>131</sup> hepatogram. Certainly this phase needs exploration, with a larger series of patients and with adequate follow-up of these cases for several years.

### Summary

The metabolic pathway of I<sup>131</sup> tagged Rose Bengal has been known for many years and repeatedly documented in the past decade. Numerous methods have been proposed to help distinguish types of jaundice but these methods were either impractical for clinical consideration or gave meaningless results. A testing procedure with reproducible results, minimal patient discomfort, and an efficient scheduling of time was evolved for clinical use. The modified technic presented in this paper was tested on 41 normal controls and 43 patients with abnormal liver function states. Characteristic curves are found for liver uptake and excretion in the various diseased states and a simplified procedure was presented for determining extrahepatic obstruction.

The corrected liver uptake value was calculated by the rate of disappearance of the dye from the blood. Normal values ranged from 8 to 12, primary liver hepatocellular diseases 4 to 5, extrahepatic obstruction 2 to 4, and intrahepatic obstruction 3 to 6. Liver excretion values were lowest in the normal control and hepatocellular diseases but were significantly higher in the obstructive diseases. The 20 minute to 5 minute blood ratio was helpful in differentiating normal from abnormal liver function states and in identifying severe liver parenchymal damage. The amount of activity remaining in the blood at 24 hours also reflected on the liver's ability to take up and excrete the dye. Finally, all the normal controls reached peak liver uptake within 30 minutes while the abnormal function states required more time to obtain peak liver uptake.

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# Coronary Disease Associated With Ingestion of Mustard

JACKSON BLAIR, M.D.

THE following cases of coronary disease associated with the eating of large amounts of table mustard are reported:

1. M. K., male, age 49. At age 45 had coronary thrombosis with infarction. "I ate one sandwich with mustard at least once a day for up to 20 years, and also mustard on eggs, up to three times a day on eggs."

2. J. A. S., male, age 57. In 1963 had acute coronary attack with myocardial infarction and another slight coronary attack in 1964. "I used mustard on sandwiches every day at work and used it at home on bologna or ham sandwiches and also used considerable mayonnaise (which contains mustard)."

3. W. A., male of Polish descent, age 36. Had coronary attack with mild infarction two years ago. "I ate large amounts of mustard on ham and ham sandwiches, on hot dogs; and on hamburgers at least twice weekly, and mayonnaise every day. I used to mix powdered mustard with beer to make it stronger."

4. J. L. B., male of Slovak descent, age 45. Had acute coronary thrombosis and infarction. "I carried my lunch for years, and 90 per cent of the time had mustard on sandwiches, and also used it on hot dogs."

5. H. G., female, age 49. Had acute coronary attack and myocardial infarction. "I ate a sandwich with mustard on it every day for nine years at the shop. I also ate a lot of hot dogs and hamburgers with mustard."

6. W. B., male, age 47. At age 41 had acute coronary thrombosis with infarction. "I used a great deal of mustard as I loved cheese and ham and always put mustard on it. I also used a great deal of mayonnaise."

7. F. J., female, age 59. Died of acute coronary thrombosis and infarction. This history was obtained from her husband: "My wife ate considerable mustard with hot dogs, one or two at picnics which we had very frequently. She earlier used mustard from a jar but lately it comes in tubes and she put it on from tubes. She also used mayonnaise at least twice weekly on salad greens and on potato salad at all picnics."

8. L. K., male, age 48. Had acute coronary thrombosis and infarction. "I ate two or three hot dogs every night with mustard, and I used a lot of pepper on my food and drank a lot of ginger-ale." Six months following his coronary attack, his blood pressure was 185 systolic and 130 diastolic. (This additional use of pepper and ginger-ale are significant and will be commented upon later.)

9. W. L., male, age 54. At age 49 had acute coronary thrombosis with infarction. "I ate lots of mustard, two hamburgers every day, covered with mustard, for two years, and some mustard before that. Since my attack I have not eaten mustard, pepper, or pickled peppers."

The next two patients were nearest neighbors and friends of the author, as well as patients.

10. E. D., male, suffered two coronary attacks with infarction and did not survive his second coronary attack with massive myocardial infarction precipitated by exertion in sub-zero weather. He liked to eat cold meats, always with

## The Author

● Dr. Blair, Cleveland, is a member of the medical staffs, Lutheran Hospital, and St. John's Hospital, Cleveland; Lakewood Hospital, Lakewood.

large amounts of mustard, for luncheon and very frequent evening snacks.

11. F. D., male, suffered an acute coronary attack with infarction. He was very fond of ham and ate it at least once or twice a week over a period of years, always with mustard. He survived his first attack but succumbed to complications, one facet of which was myocardial insufficiency.

12. Another victim of coronary thrombosis with myocardial infarction was a man age 50, whose wife informed me that he ate a large amount of pepper, mustard, ginger, but whose favorite pastime was to sit in front of his television set with a bag of pretzels and a jar of mustard, break off a piece of pretzel, dip the broken end in the mustard, and enjoy TV and pretzels a la mustard.

It is the author's opinion that mustard is the dietary agent responsible for the primary injury leading to the coronary atherosclerosis, and probably responsible in some cases to triggering the thrombosis.

What are the steps leading to such a hypothesis and conclusion?

## Pepper, Mustard, Ginger, in Hypertension

In 1948 the author<sup>1</sup> reported 50 cases of hypertension in excessive users of the hot condiments pepper, mustard, and ginger and presented the theory that excessive eating of these condiments is a common cause of essential hypertension, that hypertension may be produced experimentally by repeated feeding of these condiments, and that the damage may be irreversible.

In 1957 Roth and Blair<sup>2</sup> produced hypertension in rats by feeding these condiments and showed that the hypertension persisted for months after the condiments were discontinued.

Of pepper, mustard, and ginger, the most irritating appeared to be mustard, which contains not less than .006 per cent of the most poisonous of the volatile oils, allyl isothiocyanate ( $C_3H_5NCS$ ). The author first suspected the allyl isothiocyanate because in the reports of fatal cases of oil of mustard poison-

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ing the blood and urine had the odor of horse-radish and horse-radish contains the poisonous allyl isothiocyanate.

The author having pinpointed this chemical, Roth and Blair<sup>3</sup> produced hypertension in all experimental rats placed on breeder's diet plus allyl isothiocyanate; and in 1959 the author stated this work appears to open an entirely new approach to the etiology of arteriosclerosis and coronary disease.<sup>3</sup>

### Mustard in Atherosclerosis

The initial role of mustard in the production of atherosclerosis was suspected for many reasons.

Sollmann<sup>4</sup> states, "the sharp taste and irritation which black mustard seed develops on contact with water is due to the formation of the volatile oil, allyl isothiocyanate, by the action of the enzyme myrosin on the glucoside sinigrin, and is the most irritating of the volatile oils, and, in pure form should not be touched, tasted or smelled."

The oil of mustard has a strongly injurious effect upon the walls of the capillaries<sup>5</sup> and consequently the mustard burn is very slow of healing.<sup>5</sup>

Mustard is absorbed from the stomach into the blood stream and the previous ingestion of mustard may be detected by the finding of allyl sulfide in the urine.

Thiocyanate was used in the treatment of severe hypertension some years ago but was abandoned for it was associated with severe toxic effect and high incidence of thrombophlebitis. Another example of association of mustard with thrombotic phenomena was the case of attempted abortion with a douche of powdered kitchen mustard in hot water reported by Lovitt<sup>6</sup> where autopsy showed pulmonary embolism, lower nephron lesions, acute ulcerative bronchitis, and microscopically, embolism in the veins of the uterus with early organization and thrombosis and an acute inflammatory exudate in the adventitia of these vessels.

### Vesiculation and Ulceration Caused by Mustard

Sollmann<sup>4</sup> produced erythema, then vesiculation and later ulceration of the skin by application of mustard poultices. Since mustard or its active agent allyl isothiocyanate can produce ulceration of the skin, would not a similar ulceration of the intima of an artery (or on a previously produced atheroma), and this ulceration being bathed with blood, produce or favor the production of a thrombus or thrombosis?

Because allyl isothiocyanate is a strongly irritative and corrosive chemical it is probable that one of the earliest sites of its tissue damage, dependent on its concentration, be near the first places reached in the circulatory system, the aorta and coronaries, and where the hemodynamic action of the heart exerts its principal action.

The specific cause of the formation of the atheromatous plaque has been sought for years without

EDITOR'S NOTE: If they had been submitted to present-day medical journals, it has been said, Withering's observations on the diuretic properties of foxglove would have been rejected forthwith. Who would accept the uncontrolled observations of a country physician regarding the therapeutic properties of a brew made from the leaves of a common garden flower? Two hundred years later, however, we are still trying to explain the mechanism of action of this remarkable brew.

Who will accept, on the basis of his uncontrolled observations and incomplete documentation, Dr. Blair's contention that the ingestion of mustard plays a role in the pathogenesis of hypertension, atherosclerosis, and intravascular thrombosis? Not I. Yet, the author, a general practitioner from Cleveland, asks only that his observations be given the light of day and that "a few individuals, other than myself, . . . approach the question with an open mind and confirm or refute the laboratory experiments, reviews of clinical cases, and reviews of the epidemiology in the light of my findings."

If it appeared likely that the etiology of the vascular phenomena in question might be fully explained by any of the mechanisms now the subject of much discussion in medical literature, we would have rejected this paper without further ado. However, we find ourselves somewhat in the position of Dr. Richard W. Watts of Rocky River (through whom the manuscript was sent to us), who wrote "I realize the observations are somewhat unusual and personally I can't substantiate them but at least it represents a different viewpoint which may, or may not, be borne out in the experience of others." Accordingly, we have accepted the manuscript essentially as submitted.

Perhaps the reader finds our analogy with Withering and foxglove farfetched or inappropriate. Would he like to try Jenner and cowpox in its place?

— P. R. A.

success but many observers believe an injury to the intima or blood vessel wall precedes the formation of the atheroma.

### Similarity of Atheroma and The Cauliflower Ear

The author believes the formation of the atheroma is not unlike the sequence following the blow to a prize fighter's ear (here a mechanical injury) causing production of a serous swelling or a hemorrhage, followed by fibrin clotting, organization and deposit of lipids, cholesterol and calcium and ending with

the cauliflower ear. The formation of the atheroma probably follows a similar pattern (except the injury is chemical) with vesiculation and perhaps a deeper injury to the capillaries or to the vasa vasorum of Winternitz, and then repair by the deposit of lipids, cholesterol and calcium.

### Selectivity of Coronary Disease And Hypertension

Coronary disease is so widespread in this country that anyone would appear to have an opportunity to develop it whatever its cause might be.

The author believes that nowhere save in the allyl isothiocyanate found abundantly in mustard, is there a substance so likely and capable of being the etiological cause of the original injury, and which is so available on a selective basis, for in 1960 over 53,000,000 pounds of mustard were either imported<sup>7</sup> or grown<sup>8</sup> in the United States.

### Inheritance by Gens or Inheritance Of Customs

Heredity has been suspect, but heredity is of two parts: inheritance of body from parents and ancestors, and inheritance of culture, customs, and diet. In the case of both hypertension and coronary disease the author believes the gens of heredity have little part, but the inheritance of a diet pattern, or habits of eating, has by far the major influence.

### Fallacy of Accepted Conclusions In Epidemiology

Important supports for the cholesterol theory are the reports of reduced coronary disease in Norway and Germany in World War II and the conclusion drawn that the reduction of fats in the diet was responsible. The author believes this conclusion is not true, but rather the true conclusion is that mustard was less available at that time, for shipping problems were too great, and more importantly, the mustard fields of Sweden and Denmark were used to produce food crops and not mustard and, consequently, the lesser use of mustard was responsible for the reduction of coronary disease.

Another case in point is the low incidence of coronary disease in the Roseta Colony of Italians and the fairly high incidence of hypertension. This was to be expected. The Italians in general eat quantities of pepper and therefore have a high level of hypertension, but they are so devoted to the pepper

they eat practically no mustard and therefore have very little coronary disease. At least I believe that is the answer to the findings in the Rosetans.

Limits of space preclude listing all of the epidemiological findings, and the clinical, and experimental facts, known to pertain to essential hypertension and coronary disease, but suffice it to say, the whole of this vast evidence appears to fit into the theories, hypotheses and experiments outlined in this paper like a gigantic picture puzzle nearing completion. (Even the humoral mechanisms of hypertension including angiotensin and pressure substances, salt retention, cardiac enlargement, etc., fit into the final picture, but are, the author believes secondary to and follow the initial injury produced by the hot condiments.)

### Prevention of Coronary Disease And Hypertension

In conclusion an effort has been made to review previous work with hot condiments; to report cases of coronary thrombosis and myocardial infarction associated with the eating of mustard; to point out the poisonous nature of the allyl isothiocyanate of mustard; and to enumerate its harmful effects on the skin, its absorption from the stomach into the blood stream, its injurious effects on the capillaries, and its burn as being slow in healing.

The author is of the opinion allyl isothiocyanate is the underlying cause of the production of the majority of cases of atheromatous sclerosis, that it has thrombotic properties and may even play a part in triggering some cases of the actual coronary thrombosis, and that the restriction of the hot condiments offers a means of prevention of the majority of the cases of so-called essential hypertension, and coronary disease, and merits the consideration of the clinician, epidemiologist, and laboratory research investigator.

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**SICKLE-CELL ANEMIA.**—A combination of alkali and magnesium has been found helpful in the treatment of sickle-cell anemia. Six cases are fully described. There was no effect on the hemoglobin level and red-cell survival time. The number of painful crises could, however, be reduced, and five of the patients were enabled to lead a normal life.—*British Medical Journal*, 2:226-229, July 25, 1964.



# Adenocarcinoma of the Appendix

MAHENDRA R. PATEL, M. D.

ADENOCARCINOMA of the appendix is a very rare disease. Of the various malignant tumors of the appendix, adenocarcinoma is the least common. Because of its rarity the available information in the literature regarding this disease is mostly in the form of case reports. For this same reason, statistical data from various centers differ. Because of its low incidence, any individual surgeon does not see enough cases to comment on the basis of personal experience. Adenocarcinoma of the appendix has never been diagnosed clinically. There are no pathognomic signs and symptoms. Most of

## The Author

● Dr. Patel, Elyria, 1958 graduate of B. J. Medical College, Ahmedabad, Gujarat, India, currently is Resident in Orthopedics at Elyria Memorial Hospital.

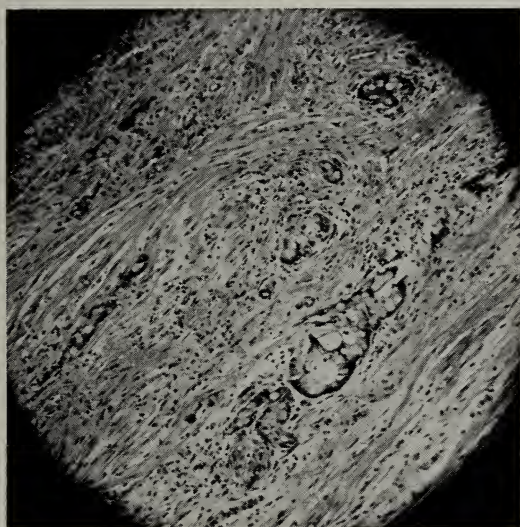


FIG. 1. (Case No. 1.) Microscopic section showing the invasion by the tumor cells in the muscular layer. Tumor cells form gland-like structures which contain many goblet cells. There is also lymphocytic infiltration. Enlarged print of magnification X100.

the cases are incidental findings in the appendices which have been removed surgically. In this paper, we present two cases and a review of all the literature available.

## Case Report No. 1

This 74 year old white man was admitted on October 15, 1962, for elective repair of a right inguinal hernia. He complained of a dull ache over the right groin since March, 1961, which was thought to be due to the inguinal hernia. There were no urinary or bowel symptoms. Physical examination and laboratory findings were essentially normal except

for the hernia. The day after admission, he was brought to surgery for repair of the hernia. There was a large indirect hernia. Digital exploration of the abdominal cavity, after opening the sac, did not reveal any abnormal findings. The appendix was easily accessible and did not appear normal. An incidental appendectomy was done, and the hernia was repaired.

The tip of the appendix was grayish white, slightly enlarged, and firmer than usual. No lymph nodes were felt. The lumen was obliterated in the distal portion. Microscopic examination showed well differentiated adenocarcinoma of the appendix involving the distal third. There was invasion by the tumor in the muscular wall, and a few cells were seen in the serosal layer (Fig. 1). Right hemicolectomy was recommended; but the patient developed bilateral bronchopneumonia, which delayed the procedure. At the second exploration, the liver was smooth and normal and there were no grossly enlarged lymph nodes. The right hemicolectomy was done. Gross examination of the specimen did not reveal any abnormality. Various sections of the base of the appendix failed to reveal any tumor cells, and the lymph nodes showed no evidence of metastases. After an uneventful recovery he was discharged in satisfactory condition.

## Case Report No. 2

This 53 year old white man was admitted to the hospital for abdominal pain of about 48 hours' duration, localized to the right flank area. There were no urinary symptoms. Bowel movements were described as normal. He had been in good health until the present illness except for some abdominal bloating and discomfort for the past several months. Physical examination revealed a well developed, fairly well nourished, white man with a temperature of 100°F. Examination of the abdomen revealed mild tenderness over the right flank area with some muscle guarding and rebound tenderness localized just below the umbilicus. Rectal examination revealed no masses or tenderness. The remainder of the physical examination showed no abnormalities. The white blood cell count was 15,000/cu. mm.

The patient was taken to surgery with a preoperative diagnosis of acute appendicitis or acute cholecystitis. Exploration through a right midparamedian incision revealed an inflammatory mass involving the appendix. There was considerable difficulty in determining whether this mass was inflammatory or neoplastic. After mobilizing the appendix, the surgeon thought it to be inflammatory, and appendectomy was decided. While removing the appendix, its base broke leaving a defect in the cecum measuring about 1 to 1.5 cm. in diameter. The mucosa of the cecum was palpated by the finger and it did not reveal any lesion. A catheter cecostomy was done through this opening, and the wound was closed. Microscopic examination of the specimen showed partially differentiated adenocarcinoma

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of the appendix (Fig. 2). Right hemicolectomy was considered, but a postoperative chest film showed innumerable small nodular densities of various sizes throughout both lung fields, suggesting carcinomatosis. The patient was discharged after an uneventful recovery without the right hemicolectomy.

He did well at home for about three months after which time he developed almost complete obstruction of the small bowel and was hospitalized. Physical examination was essentially normal except for a mass in the right lower quadrant and a mass was felt on the left by rectal examination. A chest x-ray showed some increase in the size of the previously described nodules. He was treated by nasogastric

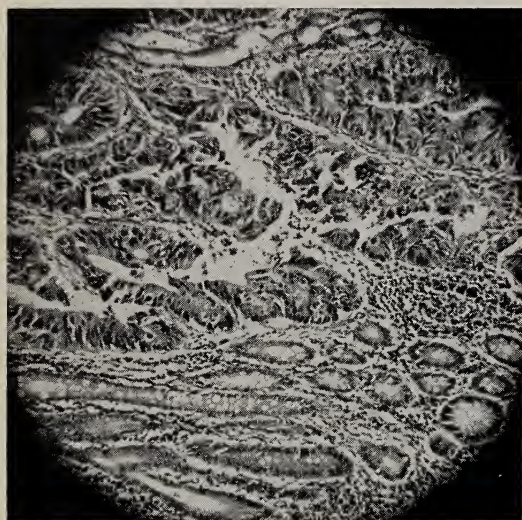


Fig. 2. (Case No. 2.) Microscopic section, showing normal mucosa and the tumor cells. There is leukocytic infiltration. Enlarged print of magnification X100.

tube suction and fluid replacement. The obstruction was relieved, and he was discharged. While at home, he developed thrombophlebitis in the legs and had multiple small pulmonary emboli. His condition deteriorated, and he finally died six months after the diagnosis of carcinoma of the appendix was made.

## DISCUSSION

### Incidence

The tumors of the appendix are about 0.5 per cent of all the gastrointestinal neoplasms.<sup>1</sup> Of the malignant tumors of the appendix, the most common is carcinoid which occurs in 88 per cent of reported cases. The next most common is pseudomucinous cystadenocarcinoma in about 8 per cent of the cases. The least common is adenocarcinoma, its incidence being 3.5 per cent.<sup>3</sup> In an extensive study by Collins<sup>4</sup> in which 50,000 appendices were studied, only 41 cases were reported as adenocarcinoma. This shows the incidence in this series as 1 in 1200 appendectomies or 0.082 per cent. Raiford<sup>5</sup> reported the incidence as 0.025 per cent and 0.3 per cent of all appendiceal tumors. Hyman<sup>2</sup> reports the incidence of tumors in surgically removed appendices as 0.35 to 0.38 per cent.

It has been described as more frequent in the male, but some series have reported an equal sex distribution.<sup>11,12</sup> Both the cases reported here are

male patients. The age varies from 15 to 89 years, but it is most common in the fourth to sixth decade of life.

### Diagnosis

It is extremely difficult to diagnose a case of adenocarcinoma of the appendix clinically. In both cases presented here, it was an accidental finding. Most of the cases manifest themselves as acute appendicitis. In a series by Niceberg, Feldman and Mandelberg<sup>6</sup> in which they reviewed the American, Canadian, and the British literature from 1930 to 1954, the most common preoperative diagnosis was acute appendicitis. In a series of 55 cases described by K. Cruze, Dubrow and Hill,<sup>7</sup> 34 cases presented as acute appendicitis, 12 cases as right lower quadrant mass, seven as recurrent abdominal pain, five as gynecological disease, and two with other symptoms and signs.

J. K. McGregor and D. D. McGregor<sup>8</sup> reported a series of 63 cases out of which 35 were diagnosed clinically as acute appendicitis, three as chronic appendicitis, seven as idiopathic right lower quadrant pain, and five as right lower quadrant masses of undetermined etiology. In 10 cases, the patients were asymptomatic, and incidental appendectomies were done. In the remaining three cases, the diagnoses of perforation of the appendix or carcinoma of the cecum were entertained. Brown and Husni<sup>9</sup> reported that out of 53 cases, 32 were diagnosed as acute appendicitis, three as subacute appendicitis, 10 as right lower quadrant mass of which three were abscesses and seven were found at incidental appendectomies. Only one case was diagnosed by x-ray studies preoperatively. Weiner and Sala<sup>10</sup> described a case of intussusception of the appendix due to carcinoma of the appendix.

### Pathology

The most common operative findings as described by K. Cruze, Dubrow and Hill<sup>7</sup> were ruptured appendix in 22 cases, liver and/or distant metastases in 10 cases, as an incidental finding in seven cases, and malignant mucocele in five cases. Perforation is a common operative finding and is supposed to be due to the obstruction of the lumen by the tumor. In well-advanced cases, growth in the appendix may be evident. Those cases which manifest themselves as acute appendicitis showed signs of inflammation and peritonitis, and some showed perforation.<sup>7,12,15</sup>

The gross appearance depends on the growth of the tumor. In those cases in which it was an accidental finding in the incidental appendectomies, the appendices were slightly swollen, thickened, indurated and had some scarring.<sup>12-14</sup> In a few advanced cases growth was noticed at the time of the surgery.<sup>7,13</sup> In the cases reported here, the appendix was thick, indurated, and firm in the distal portion in one case, and in the other there was severe inflammation.

As to the location of the tumor, Whelan and Rast<sup>15</sup>



described the tumor in the distal two-thirds in 23 cases in the proximal third in the 20 cases. Microscopically, the tumor shows gland-like structures lined by columnar epithelium containing many goblet cells. Cytoplasmic activity is often characterized by mucin formation. The nuclei are hyperchromatic and occasionally show mitosis. Two types of growth are described, one which grows towards the lumen and one which grows peripherally. Those which grow inward obliterate the lumen, and this potentiates the infection and rupture. In those cases in which it grows peripherally, there are early local and distant metastases.

#### Treatment

Two types of treatment are recommended. In those cases, where the tumor is localized to the mucosa and in the distal portion only, simple appendectomy may be adequate. In those cases where there is invasion in the muscular and the serosal layers, appendectomy with primary or secondary hemicolectomy is recommended. Simple appendectomy for the adenocarcinoma of the appendix was associated with 26.9 per cent mortality in three years, whereas the mortality was only 8.3 per cent in those cases where it was supplemented by primary or secondary right hemicolectomy.<sup>6</sup> Sieracki and Tesluk<sup>16</sup> described 10 deaths and recurrence in eight cases in a series of 50 cases. In their own eight cases, four patients died and four were reported alive from 10 months to four years postoperatively. The overall survival rate is approximately 50 per cent, although adequate follow-up studies are not available.<sup>15</sup>

In a series of 63 cases reported by McGregors,<sup>8</sup> 57 were adenocarcinoma of the appendix. In the other six cases adenocarcinoma was restricted to a polyp. Of these, 42 were treated only with appendectomy. There were five deaths in the immediate postoperative period; two died of unrelated causes; 15 had no recurrence in the follow-up from 2 to 15 years, three had recurrence in less than one year, and the remaining could not be found for a follow-up. Two patients, in whom carcinoma was restricted to the polyp only, underwent primary right hemicolectomy, and in three cases in which tumor was localized to the appendix a primary right hemicolectomy was performed. Fourteen cases had secondary right hemicolectomy. In those cases treated by primary or secondary colectomy, only one patient died. In the whole series, the operative procedure was not known in two cases. It is clear that the prognosis is very good in those cases where the tumor is found accidentally in the incidental appendectomy.

#### Conclusions

Adenocarcinoma of the appendix is very rare and is very difficult to diagnose clinically.

Most of the cases manifest themselves as acute appendicitis. Even though this is a rare tumor, the surgeon should consider its possibility when dealing with a perforated or acute appendicitis in an elderly patient. If there is any doubt, a diagnosis by frozen section is advised. If it shows tumor cells, primary hemicolectomy is recommended. Sometimes it can be very difficult to decide whether the primary tumor is in the appendix or in the cecum.

Whenever it is possible, exploration of the abdominal cavity should be carried out. During any operative procedure, if the appendix is easily accessible, an incidental appendectomy should be performed thereby reducing the chances of the malignancy, even though the incidence is low.

Treatment should be simple appendectomy or right hemicolectomy, depending upon the invasion of the tumor in the muscular and the serosal layers.

In this paper, two cases of the primary adenocarcinoma of the appendix are presented. In the first case, the tumor was found after an incidental appendectomy with the patient alive six months postoperatively. In the second case, the tumor in the appendix was associated with severe inflammation and unrecognized distant metastases were demonstrated postoperatively. The patient died within six months of the diagnosis of the tumor.

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*Prospective Contributors of Scientific Papers*  
See INSTRUCTIONS, Page 742, This Issue

# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

C. R. MACPHERSON, M. D., *President*

## PRESENTATION OF CASE

**T**HIS white housewife, aged 42, was admitted to the emergency room immediately following an automobile-pedestrian accident. She had no loss of consciousness and complained of immediate severe pain in her pelvic region.

### Physical Examination

The patient was slightly obese and had a blood pressure of 112/80, pulse rate of 112, respiratory rate 24 per minute. Neurological examination was entirely negative. The chest moved well, with no local tenderness, and was clear to auscultation. There was marked tenderness over the right lower quadrant of the abdomen and even more tenderness over the pubis on compression of the iliac crests. There was an area of contusion over the left upper quadrant. A 4 cm. laceration was seen in the right perirectal area with apparent protrusion of some rectal mucosa and total rectal incontinence. An enormous, ragged dirty laceration extended almost the full length of the right thigh up over the lateral aspect of the right lower quadrant of the abdomen. Examination of the left leg showed an open trimalleolar fracture with dirt and debris ground into the tissues.

### Laboratory Studies

X-rays showed a fracture in the left superior ischial ramus near the acetabulum and a fracture of the inferior pubic ramus bilaterally, and the left sacroiliac joint was widened. Films of the left ankle showed a fracture of the fibular shaft, and a diagonal fracture of the distal tibia extending into the tibio-talar joint. The admission hemoglobin was 11.3 Gm. and the white blood cell count 9,700. Urinalysis was negative and especially no red cells were seen.

### Hospital Course

The patient was given gas gangrene and tetanus antitoxin. Levin tube drainage was started; a catheter was placed in the bladder; intravenous therapy including blood, tetracycline and penicillin was given. The patient was taken to the operating suite from the

## Presented by

- Thomas B. Quigley, M. D., Clinical Professor of Surgery, Harvard Medical School, Boston, Mass., and
  - Jacob W. Old, M. D., Columbus.
- Edited by Dr. Old.

emergency room. The ankle fracture was irrigated, debrided, and the fragments were positioned as well as possible. The thigh wound was found to be an avulsion of skin and soft tissue. A hand could be passed from the thigh wound around the right buttock to the perineal laceration. The gluteal muscles were separated from the greater trochanter. The perineal wound extended dorsal to the rectum over a wide area of the left buttock. The bladder and rectum were intact.

During this procedure the patient's blood pressure fell and 11 pints of blood were given. Abdominal paracentesis done in the operating suite was negative. During the first 48 hours postoperatively, the patient required 1 unit of blood per 24 hours to maintain blood pressure. At 8 p. m. on the day of admission a second negative peritoneal tap was done, and the patient had a good urinary output. After 48 hours it was noted that the wounds were draining copious quantities of serous fluid. She was placed on a Striker frame and turned frequently. Culture of the wound grew non-hemolytic *Staphylococcus aureus*, enterococci, and *Escherichia coli*. The patient continued to run a temperature from 101 to 103°, pulse rate between 100 and 130 per minute. Her urine output continued adequate. The thigh and perineal wounds were necrotic. Cultures on the eighth postoperative day grew, for the first time, *Clostridium welchii*.

She was taken back to the operating room and the gangrenous tissue was debrided on the eleventh day. A double-barrel sigmoid colostomy was also done. No intra-abdominal fluid or hematoma was noted.

Submitted May 19, 1965.



Over the next 48 hours her temperature fell and remained near normal for the following three days. The urine output remained between 500 and 600 cc. per day. The patient took oral fluids very poorly, and on the third day following her second operation she developed abdominal distention and Levin suction was instituted.

A third debridement was done 16 days after her admission. Her pulse rate continued to be elevated, and peripheral edema appeared. Abdominal films at this time showed a paralytic ileus. The white blood count was 47,000 and the hemoglobin 16 Gm. The blood urea nitrogen was 21 mg./100 ml., the serum sodium 123, potassium 4.2, and chloride 83 mEq./L., the CO<sub>2</sub> combining power 24 vol./100 ml. A repeat portable supine film showed a considerable area of mottled appearing shadows over the right lower abdomen.

The abdominal distention persisted, and she was taken to the operating room for the fourth time 20 days after her admission. The perineal and thigh wounds were again cleansed and debrided. There was still no evidence of healing. On the twenty-first hospital day she was noted to be mentally confused and her abdomen was rigid. Another paracentesis, done in the epigastrium, yielded 1600 cc. of serous, yellowish fluid with a fecal odor. The patient died on the twenty-second day.

#### CLINICAL DISCUSSION

DR. R. D. WILLIAMS: Dr. Thomas B. Quigley is Clinical Professor of Surgery at a small school east of here in Boston which is fairly well known, as is Dr. Quigley. His particular interest fits nicely into the presentation today, which is one dealing with multiple trauma, and I am sure Dr. Quigley will give us an interesting discussion of this. Dr. Quigley.

DR. QUIGLEY: I submit that we are concerned in this case with the last 22 days of life of this unfortunate 42 year old, slightly obese white woman. First we have an accident and then on the eleventh day is another medical incident. We then go on four days to another medical incident, another three days to another incident, two more days and death. She is described as being the victim of an auto-pedestrian accident. She had no evidence of injury to her head or to her thorax, and her blood pressure, pulse and respiratory rate, in view of subsequent description of her injuries, seem to me to have been surprisingly good.

The abdomen presented the beginning of what might be something important with considerable tenderness in the right lower quadrant. There was a contusion of the left upper quadrant that may or may not be significant, but this is one of those facts that you should file away to recall should further evidence present. Compression of the iliac crests produced considerable pain. There was also this dreadful laceration — the full length of the thigh, up over the

lateral aspect of the right lower quadrant of the abdomen — and an extraordinary injury to the anus with protrusion of rectal mucosa and total rectal incontinence.

#### Mechanism of Injuries

The mechanism of injuries is well worth trying to analyze. I submit that it will help your thinking and raise your index of suspicion about injury to hidden parts of the body that might not otherwise come into focus. Perhaps we can get a clue to the mechanism of this injury, first, from this open trimalleolar fracture since patterns of fracture of the ankle can reveal the mechanism of injury, as through a glass darkly, although I think I can see what may have happened here. The talus has been moved toward the lateral side, and here is the distal tibia, at which point the soft tissue broke and dirt was ground in. This pattern of fracture is one in which the ankle, the foot, and the tarsus are rotated outward and abducted, pushing the distal tibia medially through the skin and into the street.

I had hoped the pattern would be somewhat different because it would have supported my theory that the injury to the thigh was of the avulsion type, which raises the possibility that a tire of a vehicle had avulsed her soft tissues in the same pattern as in children who catch an upper extremity in a wringer, whereupon a split occurs, and there is always a much more serious injury below the skin than there would appear to be on the surface because the skin and subcutaneous tissue, and very often the muscle itself, are simply torn off the bone. I would assume that some such mechanism operated, particularly in view of the fact that later we learn that the gluteal muscles were torn off the greater trochanter and a hand could be passed upward from the laceration in the thigh to this laceration about the anus. On admission she had not lost a great deal of blood, and it is interesting too that we have a baseline urinalysis which showed no evidence of injury to the kidney or bladder.

She was taken to the operating room. Things began to happen here, and I am very sympathetic with the surgeons, because her blood pressure fell and 11 units of blood were necessary. I doubt very much indeed if this resulted from the debridement because I am quite certain that the technical skill of this staff is quite able to cope with the bleeding produced by debridement. Where then did this woman bleed? She had a very severe fracture of her pelvis, she was probably subjected to considerable kinetic energy to the pelvis, and the stage had been set for bleeding from cancellous bone in this area. Such bleeding can be severe, insidious, and very difficult indeed to cope with. Also, the time interval between injury, emergency ward and operating room is about right for her to have lost a considerable amount of blood behind her peritoneum and in her pelvic basin from this fracture. I can hardly overemphasize the im-

portance of watching for quiet bleeding from pelvic fractures.

### Anal Injury

Again this extraordinary injury to the anus comes into focus at this operation. The statement is made that the bladder and rectum were intact. We know the bladder was intact because we had a catheter in it and there was no blood. But the "rectum was intact," yet earlier it said that rectal mucosa prolapsed. I ask here the classic question that Dorothy Parker is said to have asked when she was informed that Coolidge had died: "How do they know?" So how do they know that this rectum was intact?

DR. WILLIAMS: What this implies is that the anus was torn through, but the rectal mucosa was not torn.

DR. QUIGLEY: I see. Well, she was not allowed to get into serious difficulty in the operating room, and the most cheering statement is that she had a good urinary output. She was very wisely placed in a Striker frame and turned frequently. So here was quite a lot of trauma plus the necessary, guided, purposeful trauma of surgery, and everything had gone pretty well to this point. The wounds on the thigh we feel sure were not primarily closed because they were draining copious quantities of serous fluid. She grew the ubiquitous, inescapable staphylococcus together with, understandably, enterococci from her anal wound. She had moderate but understandable fever. Her pulse was a little high and I should think a little worrisome. She continued though to get along pretty well in that she was taking clear liquids. Was she moving her bowels?

DR. WILLIAMS: Yes, she was.

DR. QUIGLEY: Then that will explain, if we needed any explanation, why the Welch bacillus was presently found in the wound. This is, as I'm sure you all know, an almost normal inhabitant of the human gastrointestinal tract. Welch bacillus isn't necessarily immediately lethal. It needs dead tissue to live on and preferably dead tissue without adequate access to the outside world. I am sure that debridement and the general surgical procedure did not give the Welch bacillus this opportunity. Then she went along to the second traumatic event on the eleventh day. Her wounds must have smelled pretty bad and must have been rather offensive to any surgical conscience. Debridement was done here, and a colostomy. At the time this was done I am sure a relatively limited, but nevertheless important, inspection of the inside of the abdomen was carried out and presumably nothing very abnormal was discovered. Is this correct?

DR. WILLIAMS: Right.

DR. QUIGLEY: This must have been heartening. This debridement did her a lot of good. Her temperature fell and remained pretty normal for the next three days. But she had to have some albumin,

intravenous fluids or blood transfusion, and a *very significant statement is made*. In contradistinction to what was happening before the colostomy, she "took oral fluids very poorly," and on the third day after this event she got distended and the tube was put back in her stomach. Her pulse rate was elevated, some edema appeared. A third traumatic event then occurred with another debridement 16 days after admission. I'd like to see the abdominal film taken at this time and be educated a little about the difference between paralytic and any other kind of ileus as seen in a plain x-ray of the abdomen.

### Ileus

DR. DUNBAR: I agree that there is intestinal gas without evidence of mechanical obstruction, which is essentially what the radiologist means when he says "paralytic ileus." A diagnosis of ileus implies that there is no mechanical obstruction and that there is a peritonitis, generalized avascular disease of the intestinal tract, or some other cause for stasis and poor muscular activity with collection of gas.

DR. QUIGLEY: Another way that you can tell whether you have something mechanically blocking progress of peristalsis, or something paralyzing the bowel primarily, is to listen to the belly with a stethoscope. Was this done?

DR. WILLIAMS: Yes, observations were made that the "bowel sounds were depressed." Repeated observations were made regarding this and apparently intermittently there were changes in the sounds heard in the abdomen over a number of days' time.

DR. QUIGLEY: The statement is made several times that non-healing of the wound was noted. Why don't wounds heal? Nature is very kind; wounds heal despite pretty nearly every kind of barrier that can be placed in the path of wound healing. One has to have a very depressed protein level or be beyond ordinary starvation and practically cachectic. About the only explanation I can offer for this repeated remark is that a mixed flora of bacteria was present which was acting as a local barrier to proper granulation.

Now at this point, people were beginning to worry more again. The white count was 47,000 and that's a very high count. Her hemoglobin was 16. This might be evidence that she was getting concentrated, yet her chemistries were slipping down a bit as if she were not getting quite enough sodium chloride replacement. Here for the first time we note that she had abnormalities in the tubular function of her kidneys. She certainly had plenty of cause for this: She had had a great deal of badly damaged muscle and she had received many transfusions. Now we come to another radiologic clue and that is "a considerable area of mottled appearing shadows over the right lower abdomen." Could we see this?

DR. DUNBAR: I would make the comment that



this description suggests abscess to me but this film helps me not at all, really. Intra-abdominal abscesses look exactly like fecal material in the colon and I think many are missed because of this fact. It's very nice to have some contrast in the colon, if there is an area you are worried about, in order to identify the G.I. tract for what it is. You are sometimes surprised that you can then recognize an abscess as big as an orange or grapefruit that you didn't appreciate at all without contrast.

DR. QUIGLEY: Still another debridement was done on the twentieth day. Things were slipping generally and thereafter she was mentally confused. In other words, she was terminal. Still another paracentesis was done; so the surgeon was very suspicious that something had been going on from the very beginning, and at this time 1600 cc. of serous yellowish fluid with a fecal smell was aspirated, and she died.

What does all this mean? The patient was stable abdominally for 11 days, when a colostomy was done to control wound contamination. This becomes the key event in this woman's history. Whether this has a causal or only a temporal relation is the problem. If the colostomy had a causal relationship to the events which followed, then mechanical intestinal obstruction would seem to be a reasonable explanation for everything that happened to her, except for the radiologist's rather firm feeling that there was no radiologic evidence of this. If the relationship here is temporal and the colostomy had no role in the event, then what could have happened? Perhaps progressive retroperitoneal sepsis with mixed flora, spreading the leaves of the mesentery, could produce vascular interruption and death to a greater or lesser degree of the bowel.

What else could this almost terminal paracentesis mean? It is conceivable that the needle went into an inflated part of the gastrointestinal tract, but we will discard this as impossible in this group of skilled surgeons. It is conceivable that, unassociated with this accident and all that followed, this woman developed appendicitis which ruptured and she got peritonitis. Finally, it is not inconceivable that with a contusion in the left upper quadrant the pancreas could have been contused, and that in three weeks a great pseudocyst developed which got infected and the needle went into that.

I submit then that this woman died of peritonitis, that the probability is that this was a paralytic ileus due to retroperitoneal sepsis, but almost equally possible, despite the radiologist's opinion, a mechanical obstruction following colostomy. I think that concludes my observations.

#### CLINICAL DIAGNOSIS

1. Multiple trauma.
2. Retroperitoneal sepsis.
3. Paralytic ileus.

#### PATHOLOGIC DIAGNOSIS

1. Multiple trauma.
2. Laceration of anterior cecum.
3. Generalized peritonitis.

#### DISCUSSION OF PATHOLOGY

DR. OLD: This was a masterful discussion of clinical things dealing with trauma the results of which we can no longer see at autopsy. Quite obviously, things had been sutured and cleaned up, and except for where the wounds went and how they were sewn together we can say very little about them internally. We do not ordinarily make examinations into the soft tissues surrounding bone, so we have no way of knowing whether she had a hematoma in that particular area. At the time of autopsy, we did not find any evidence of intra-abdominal hemorrhage, either old or recent, so we presume that the bleeding was not due to any type of intra-abdominal injury. Thus this 11-pint deficit remains somewhat of a mystery and the explanation you have given is the most logical.

The actual cause of death was a 1.5 cm. laceration in the taenia of the anterior cecum about 7 cm. above the ileocecal valve. From the description of the wound running up the leg, it was probably of the avulsive type as Dr. Quigley mentioned—a tear rather than a cutting injury. This avulsion wound, which carried up into the anal region, obviously had nothing to do with the rupture of the cecum itself. The forces which produced the laceration were probably some distance away from its highest point of extension, and we must presume that there was in addition some blunt injury to the abdomen.

Abdominal organs may be injured not necessarily at the point of impact and these include the liver, spleen, gastrointestinal tract, and sometimes the kidneys. The mechanism of gut rupture in trauma is not known but is considered by some to be the result of gas compression in the gut, and by others, such as our Dr. Williams, to be the result of shearing action. In this instance, if Dr. Williams' concept is correct, the cecum would very probably have been caught by blunt injury and pressed against the pelvic, possibly against the sacral, region on the right side and under these circumstances was ruptured. I presume the reason for the rather unusually long course with no pneumoperitoneum observed was that this 1.5 cm. laceration was fairly well sealed off to begin with and the nidus for peritonitis was localized for a considerable period of time. At autopsy, the peritonitis was generalized in the sense that it was all over, but accumulations of fluid and pus were definitely localized in several areas.

We thus have the actual cause of death related to the original accident with a laceration of the cecum apparently due to trauma which gave rise to later peritonitis, which the body controlled for a considerable time but which ultimately generalized. Since this patient's abdominal difficulties started after colos-

tomy, it is possible that adhesions already formed were broken by even limited exploration. The renal disease functionally never got exceptionally bad, the blood urea nitrogen only rising to about 50.

DR. WILLIAMS: Dr. Quigley, would you care to offer any closing comments?

DR. QUIGLEY: I still feel that something happened at the eleventh day. If this 1 to 2 cm. laceration in the cecum had been open to the peritoneal

cavity, I would have expected that by that time she would have been *pretty sick*. It is possible that the manipulations associated with a laparotomy could have unsealed this.

DR. WILLIAMS: I believe, Dr. Quigley, you have demonstrated very nicely that the man who gets interested in orthopedics should not forget that there may also be disease in the abdomen. Thank you very much.

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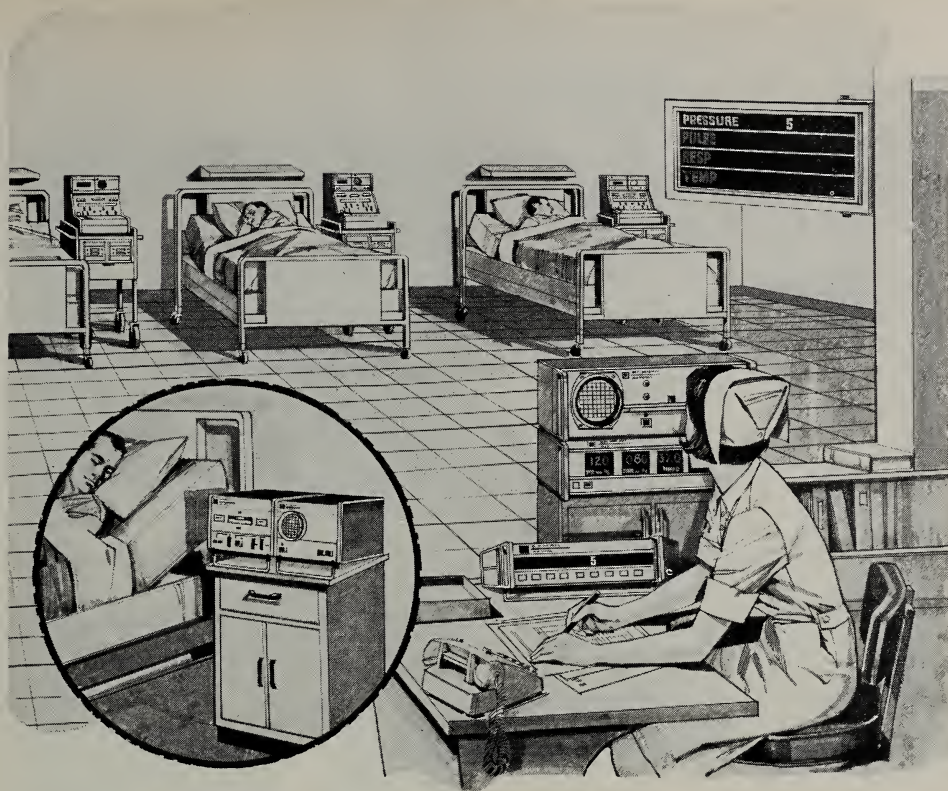
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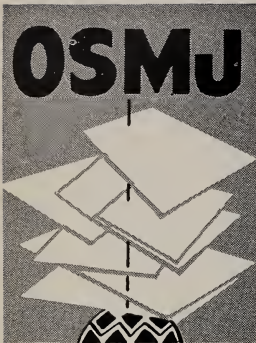
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## Reports on AMA 1965 Convention; Ohioan Named President-Elect

THE HOUSE OF DELEGATES paid the highest tribute it can offer a physician when it named an Ohioan to the top office in the American Medical Association. Dr. Charles L. Hudson, of Cleveland, was named President-Elect of the AMA and will succeed to the Presidency at the 1966 Annual Convention in Chicago.

Honors started coming to Dr. Hudson long before he graduated Magna Cum Laude from Alma College in Michigan, and Cum Laude from the University of Michigan Medical School. He has distinguished himself as a practicing physician in the Cleveland area, as an educator and as a tireless worker in the medical organization field.

Dr. Hudson is a Past-President of the Academy of Medicine of Cleveland, a Past-President of the Ohio State Medical Association and served as a member of the AMA Board of Trustees from 1961 to the present year. His achievements in various professional and non-professional organizations and his activities in behalf of organized medicine are numerous.

(See facing page for a profile of Dr. Hudson published in *The New York Times*.)

Dr. Hudson became the seventh Ohioan elected to head the AMA. Other Ohioan Presidents of the AMA were: Dr. Reuben D. Mussey, Cincinnati, 1850; Dr. George Mendenhall, Cincinnati, 1870; Dr. William Wirt Dawson, Cincinnati, 1889; Dr. Charles A. L. Reed, Cincinnati, 1901; Dr. J. H. J. Upham, Columbus, 1937 and Dr. E. J. McCormick, Toledo, 1953.

### Ohio Delegation

The Ohio State Medical Association was represented in the AMA House of Delegates by the following delegates: Dr. George W. Petznick, Cleveland, Dr. Theodore L. Light, Dayton, Dr. Edmond K. Yantes, Wilmington; Dr. John H. Budd, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Charles A. Sebastian, Cincinnati; and Dr. Edwin H. Artman, Chillicothe. Dr. Robert S. Martin, Zanesville, and Dr. Frederick P. Osgood, Toledo, both alternate delegates were seated as delegates.

Attending the meeting as alternate delegates were: Dr. H. T. Pease, Wadsworth; Dr. Kenneth D. Arn, Dayton; Dr. Harry K. Hines, Cincinnati; Dr. P. John Robeck, Cleveland, also a member of the OSMA Council; Dr. Robert E. Tschantz, Canton, also OSMA Immediate Past-President; Dr. J. Robert Hudson, Cincinnati; and Dr. Philip B. Hardyman, Columbus, also OSMA treasurer.

Other OSMA officers and Councilors who attended the convention were Dr. Henry A. Crawford, Cleveland, OSMA President; Dr. Lawrence C. Meredith, Elyria, OSMA President-Elect; Dr. Robert E. Howard, Cincinnati, First District Councilor, and Dr. Frederick T. Merchant, Marion, Third District Councilor. Dr. Edward J. McCormick, of Toledo, attended as a Past-President of the AMA. He is also Past-President of OSMA.

Accompanying the official delegation were the following members of the OSMA Headquarters staff in Columbus: Hart F. Page, Executive Secretary; Charles W. Edgar, Director of Public Relations and



THE NEW YORK TIMES, FRIDAY, JUNE 25, 1965.

# A.M.A. President-Elect

## Charles Lowell Hudson

**DR. CHARLES LOWELL HUDSON**, 61 years old, the new president-elect of the American Medical Association, is an unruffled ex-combat doctor with a fondness for showy, expensive cars. These two qualities—calmness and sedate showmanship—have propelled Dr. Hudson to the top of the

**Man  
in the  
News**

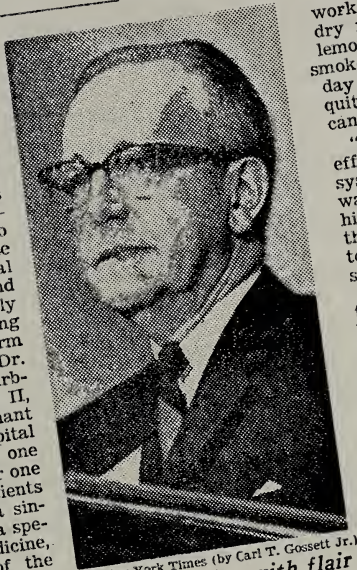
Man hierarchy, and in the will be crucially News important during the one-year term he will begin next June. Dr. Hudson proved his imperturbability during World War II, when he was a lieutenant colonel with an army hospital at Caserta, Italy, only one mile from the front. After one attack, 500 wounded patients flooded the hospital in a single night. Dr. Hudson, a specialist in internal medicine, had to decide which of the patients needed help first. "You had to exercise judgment," he observed yesterday.

Dr. Hudson's blend of conservatism and style shows in his personal car, a 1964 white Buick convertible. "I'm interested in automobiles," he said in slow, precise Midwestern tones. "I like them. It's crazy, but I do. I've never owned anything very sporty, though."

### Led a Dance Combo

His personal style also showed when he led a five-man dance combo in his undergraduate days at Alma College, at Alma, Mich., where he graduated magna cum laude in 1924. He played a saxophone, and his idea of a snappy tune was "It Had to Be You." Similarly, Dr. Hudson has, until recently, sung baritone with an amateur choral group in Cleveland, where he practices. But he eschews theatricals.

"I am not so colorful as some other presidents" the A.M.A. has had, Dr. Hudson said after his election, "but I hope I am understanding."



The New York Times (by Carl T. Gossett Jr.)  
**A conservative with flair**

Dr. Hudson gained the understanding of his medical colleagues' devices and desires in a career that began in Merrill, Mich.—then a town of 500—where he was born in 1904. His father, James Harvey Hudson, was a general practitioner there.

After Alma College, he studied medicine at the University of Michigan (M.D., 1930) and did his internship and residency at Lakeside Hospital in Cleveland. He met his wife, Ruth Strong, of an old Cleveland family, when a Cleveland hostess seated her next to him at a dinner party.

After a two-year research fellowship in pharmacology at the University of Pennsylvania, Dr. Hudson returned to Cleveland, where he is now associate clinical professor of medicine at Western Reserve University and an associate professor at the Cleveland Clinic.

The Hudsons moved in October into a new, three-bed-

room white frame house, in a Cleveland suburb. When he is not busy with medical organization affairs, Dr. Hudson gets to the clinic shortly after eight and works until six.

Dr. Hudson avoids bringing work home. He likes a very dry martini with a twist of lemon in the evening. He smoked a pack of cigarettes a day until about 1952 when he quit smoking—well before the cancer scare.

"I was impressed with its effects on the blood-vessel system," he said. "Everybody was worried about keeping his blood vessels open and I thought it was kind of silly to do anything that constricted them."

Now the only smoker in the Hudson family is Dr. Hudson's daughter Judith, 22, a Mount Holyoke graduate who works at the Smithsonian Institution, in Washington. The other children are Charles Jr., a sophomore at Lake Forest College, in Illinois, who will be 19 on Monday, and Mary, 16, a student at Hathaway Brown, a private school in Cleveland where Mrs. Hudson, a Vassar alumna with a Western Reserve Ph.D. in French history, teaches French.

Dr. Hudson, who is greying, dresses conservatively (he wore a light-weight blue suit when he was elected yesterday) and keeps his 5 foot 9 inch frame at 155 pounds, partly by playing golf and working at his vacation place in the Parry Sound district of Ontario.

His activities at the 300-doctor private clinic ("I may be bragging but I think it's the second largest in the country, after the Mayo Clinic") and in the A.M.A. leave little time for further outside activities. Lack of time led Dr. Hudson to the American Legion, although he is a three-year World War II veteran with four battle stars.

His politics is as conservative as his tailoring, and he was—and remains—an ardent supporter of Barry Goldwater.

"I am still unhappy he didn't win," he remarked yesterday.



Assistant Executive Secretary; Herbert E. Gillen and W. Michael Traphagen, administrative assistants.

### Reference Committees

The following Ohio Delegates served on Reference Committees of the House of Delegates:

Dr. Edmond K. Yantes, Wilmington, Committee on Insurance and Medical Service.

Dr. George Petznick, Cleveland, chairman, Committee on Legislation and Public Relations.

Dr. Richard L. Meiling, Columbus, chairman, Committee on Medical Military Affairs.

Dr. Edwin H. Artman, Chillicothe, Committee on Public Health and Occupational Health.

### Ohioans on Standing Committees

The following Ohioans are on Standing Committees of the Board of Trustees:

Dr. F. A. Simeone, Cleveland, Council on Drugs.

Dr. George J. Hamwi, Columbus, Council on Foods and Nutrition.

Dr. Fay A. LeFevre, Cleveland, Council on Post-graduate Programs.

Dr. Edmond K. Yantes, Wilmington, Council on Rural Health.

### Ohio Gets Words in Sideways

Most controversial issue before the House of Delegates was that of the individual physician's decision regarding nonparticipation in any medicare-like program such as that now before the Congress. While the House rejected Ohio's resolution on medicare, it did approve the report of the reference committee as a whole which included this significant statement:

"Your committee recommends that members of the American Medical Association be reminded that it is the physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

In essence this is what Ohio's resolution recommended. It called upon the AMA to "emphasize to all physicians that they are urged to maintain their professional principles, to care for their patients even without pay as before; that they not participate in any system of medical care that would lend itself to a deterioration in the quality of that care; and that they are free to decline to participate in the system of medical care established by H. R. 6675, or any similar legislation."

The House turned down nine resolutions on medicare, including the one from Ohio, but in a substitute resolution recommended by the Reference Committee on Legislation and Public Relations with Ohio's Dr. George W. Petznick, of Cleveland, as chairman, it affirmed this statement:

"Resolved, that the physicians of the United States of America pledge themselves to continue their search

and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care that has been traditional in our country."

The House overwhelmingly adopted an amendment to the resolution submitted by Ohio Delegate Theodore L. Light, of Dayton, which reiterated and reaffirmed the nine principles for health care program previously presented by the Ohio delegation and approved by the AMA House of Delegates at the special session in Chicago, February 7 of this year. (See March issue of *The Journal*, page 278.)

### Nine Principles

The nine principles are as follows:

"(1) No person needing health care shall be denied such care because of the inability to pay for it.

"(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

"(3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.

"(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.

"(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

"(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

"(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

"(8) Any such health care programs should provide funds only, and not direct services.

"(9) Funds for such programs may come from general tax revenues and not from social security taxes."

### Ethical Aspect Reaffirmed

The Ohio delegation also was instrumental in obtaining the House's reiteration and reaffirmation of Section 6 of the Principles of Medical Ethics and the Bauer Amendment.

Section 6 states, "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

The Bauer Amendment, adopted by the AMA House of Delegates in 1961, states that the medical profession will provide the best possible medical care regardless of ability to pay, and that the profession "will render that care according to the system it believes is in the public interest, and that it will not



be a willing party to implementing any system which it believes to be detrimental to the public welfare."

Dr. Petznick's committee reported on the medicare resolutions as follows:

"The resolutions before the Reference Committee, for the most part, urge the Association to adopt a stand against physician participation under the medicare bill, should it be enacted. Your Reference Committee does not recommend this action but, instead, directs the attention of the House to the arguments of those physicians who counseled that the Association wait until a law has been passed so that the effect could be accurately assessed."

While the House directed that a special session be called after such effect has been determined, it is not expected that such determination will be made until the Clinical Convention next November in Philadelphia.

#### Other Ohio Resolutions

The House referred to the Council on Medical Education a resolution submitted by the Ohio Delegation and calling for the Council to develop a method of determining eligibility of osteopaths for intern and residency training in AMA-approved hospital programs. The resolution was passed by the OSMA House of Delegates May 11.

Also referred to the Council on Medical Education was an Ohio resolution calling for endorsement of the principle of an American Board of Family Practice.

#### Offer to the President

In a related action, urging that government seek the advice of the medical profession on health legislation, the House adopted a resolution which included the following statements:

"This House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"The House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on an active campaign to inform the membership of the American Medical Association.

"The American Medical Association oppose those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education, and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the

development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members."

#### The Gundersen Committee

Action on the Gundersen Committee report reviewing the size, make-up and functions of the House of Delegates was postponed until the 1965 Clinical Convention in Philadelphia.

The Gundersen Committee was appointed an ad hoc unit at the directive of the AMA House in June, 1963. The committee, which is chaired by Gunnar Gundersen, M.D., La Crosse, Wis., a past-president of the AMA, brought in an extensive 35-page report.

The committee pointed out that certain aspects of its work were unfinished, particularly those dealing with the function of the AMA scientific sections. The AMA House action recommended that the committee continue its study of scientific sections.

#### Miscellaneous Actions

In dealing with 73 resolutions and numerous reports from councils, committees and the Board of Trustees, the House of Delegates also:

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance, and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

Instructed the Council on Medical Service and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained.

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Reaffirmed its policy that the practice of radiology, pathology, anesthesiology and physical medicine, even in hospitals, is a part of the practice of medicine.

Reaffirmed AMA policy that human blood, as

living tissue, should not be purchased under insurance contracts.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people, specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the Board to review the subject of federal assistance for operating expenses for health or medical education facilities.

Directed the Board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Referred to the Board for study a resolution calling for "a program of purchase of health insurance . . . in every state, subsidy for which shall be by federal-state participation," under which "extension of coverage shall be to all needy persons regardless of age."

Also referred to the Board for consideration and appropriate action a 10-point legislative program outlined by the Minnesota delegation.

Urged the Council on Medical Education to establish a standard date of appointment for all approved residency training programs.

Amended the bylaws to provide that the Vice-President shall succeed to the presidency should the President die, resign or be removed from office.

Accepted a Board of Trustees report stating that it had referred to the joint AMA-American Bar Association committee a previously introduced resolution designed to present a grievance against alleged abuse of legal processes, characterized in the resolution as "vexatious litigation."

#### Election of Officers

Dr. Hudson's unexpired term on AMA's Board of Trustees will be filled by Dr. Irvin E. Hendryson, Denver, Colo. Dr. Hendryson will serve until 1967.

Re-elected to the Board for three-year terms were Drs. Lester D. Bibler, Indianapolis; J. B. Copeland, Austin, Texas; Gerald D. Dorman, New York; L. O. Simenstad, Osceola, Wisc.

W. Andrew Buntin, M. D., Cheyenne, Wyo., was elected to a one-year term as the Association's vice-president.

Dr. Milford O. Rouse of Dallas, Texas, was re-elected Speaker of the House of Delegates, and Dr. Walter C. Bornemeier of Chicago was re-elected Vice-Speaker.

## Plan First Ohio Congress on Psychological Medicine

Plans for the "First Ohio Congress on Psychological Medicine" are nearing completion. This conference will be sponsored by the Ohio State Medical Association on Sunday, October 24, at the Sheraton-Columbus Motor Hotel, Columbus.

Cosponsors of the conference include The Ohio Psychiatric Association; The Ohio Academy of General Practice; Ohio Chapter, American Academy of Pediatrics; The Ohio Society of Internal Medicine and the OSMA Section on Obstetrics and Gynecology.

"The subjects to be discussed at this Congress have been chosen so as to attract those physicians who are not engaged in the specialty of psychiatry," comments Dr. Wendell A. Butcher, chairman of the OSMA Committee on Mental Health. "It is intended to be a postgraduate session."

Four topics will be presented by nationally known experts. These include: "The Community Physician's Role"; "Depressions"; "Mental Retardation" and "Management of Marriage Problems." Following each presentation, a table discussion is planned. At each table will be a non-psychiatrist table leader and a resource psychiatrist.

"It is hoped that, as the speakers make their presentations, the individual physicians present will recall everyday problems that they face in their offices and that they will discuss these during the table discussion period," Dr. Butcher adds. "If this interplay develops, our Congress will be successful."

Dr. Henry A. Crawford, OSMA President, urges all OSMA members to attend. Dr. Crawford states, "We must realize that there will never be enough psychiatrists to handle all emotional problems. Through programs like this one, OSMA can contribute significantly to the development of a knowledge of psychiatry among all physicians, regardless of their specialty."

A complete program and registration form for this Congress will accompany the August OSMAgram and will also be published in the September issue of *The Journal*.

#### Radioactive Scanning

The University of Pittsburgh is offering a postgraduate course entitled "Advances in Radioactive Scanning," to be held at the Penn Sheraton Hotel in Pittsburgh, October 21-22. Course director will be Yen Wang, M. D., associate professor of radiology at Presbyterian-University Hospital, University of Pittsburgh.

Further information may be obtained from Director of Postgraduate Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pa. 15213.



# Ohioans on AMA Program . . .

## Many from This State Presented Papers, Sponsored Exhibits Or Otherwise Participated in New York Annual Convention

**A**GAIN this year, Ohio was well represented by numerous physicians from this State who participated in the 1965 Annual Convention of the AMA in New York City by sponsoring or co-sponsoring presentations before the various scientific sessions, acting as demonstrators, or presenting entries in the various sections of the Scientific Exhibit. Following are excerpts from the official program indicating the various parts Ohioans played in the meeting.

### Ohioans on Scientific Program

Dr. Lawrence J. McCormack, Cleveland, presented a paper on "Cytology in Diseases of the Chest," before a joint meeting of the Section on Obstetrics and Gynecology and the Section on General Surgery. The program was a "Symposium on Diagnostic Cytology."

### Anesthesiology

Dr. Donald E. Hale, Cleveland, was representative to the Scientific Exhibit from the Section on Anesthesiology.

Drs. Philip E. Vanik and Hamilton S. Davis, Cleveland, were co-authors of a paper entitled "Cardiac Arrhythmias During Halothane Anesthesia," presented before the Section on Anesthesiology.

### Dermatology

Dr. Roy L. Kile, Cincinnati, was vice-chairman of the Section on Dermatology.

### Section on Diseases of the Chest

Dr. Howard S. Van Ordstrand, Cleveland, was secretary of the Section on Diseases of the Chest, and a member of the Committee of the Council on Postgraduate Programs.

Dr. Van Ordstrand, also was one of the moderators on a panel entitled "Prevention and Treatment of Postoperative Pneumonia," in a joint session of the Section on Diseases of the Chest and the American College of Chest Physicians.

Dr. Earle B. Kay, Cleveland, participated in a round-table luncheon discussion on "Aortic Stenosis—Indications for Surgery and Results," presented as part of joint program of the Section on Diseases of the Chest and the American College of Chest Physicians.

Dr. Kay also was the thoracic surgeon in a "Cine

Endoscopy Panel on Hemoptysis," in a joint meeting of the Section on Diseases of the Chest, Section on Radiology, American College of Chest Physicians and the American Broncho-Esophagological Association.

Dr. Walter H. Maloney, Cleveland, participated in another round-table luncheon discussion entitled "Progress in the Study and Treatment of Esophagitis." He was secretary of the Section on Laryngology, Otolaryngology and Rhinology.

Dr. Neil C. Andrews, Columbus, participated in a panel entitled "Choice of Therapy for Lung Cancer," in a joint session of the Section on Diseases of the Chest and the American College of Chest Physicians.

Dr. Ray W. Gifford, Jr., Cleveland, participated in a panel on "Pathogenesis of Arteriosclerosis," before the joint session of the Section on Diseases of the Chest and the American College of Chest Physicians.

Dr. Henry Bachman, Malta, participated in a panel on the subject, "Tuberculosis in 1965," before the joint session of the Section on Diseases of the Chest and the ACCP.

Dr. Frederick S. Cross, Cleveland, participated in a panel on "Postoperative Evaluation of Prosthetic Valves," before the joint session with the ACCP.

Dr. Hastings Wright, Cleveland, participated in a panel entitled the "Magic of Mannitol," before the joint session with the ACCP.

Dr. John Storer, Cleveland, was co-moderator of a discussion on "Aneurysms of the Thoracic Aorta," before the joint session with the ACCP.

Dr. Henry A. Zimmerman, Cleveland, participated in the panel on "Subaortic Hypertrophic Muscular Stenosis," before the joint session with ACCP.

### Chest Diseases and G. P.

Dr. Gerald L. Baum, Cincinnati, was one of the authors of a paper entitled "Clinical and Ethnological Aspects of Cystic Disease of the Lung," presented before a joint meeting of the Section on Diseases of the Chest with the Section on General Practice.

Drs. Herman A. Freckman, F. L. Mendez, Jr., and E. R. Maurer, Cincinnati, were co-authors of a paper entitled "The Chemotherapy of Bronchogenic Carcinoma by Continuous Arterial Infusion," presented

before the joint meeting with the Section on General Practice.

Dr. W. J. Kolff, Cleveland, presented a paper entitled "Artificial Heart Inside the Chest" before the joint meeting with the Section on General Practice."

#### Experimental Medicine

Ralph G. DePalma, M. D., Charles A. Hubay, M. D., and Stanley Levey, Ph. D., Cleveland, were co-authors of a paper entitled "The Micellar Properties of Bile," presented in the meeting on "Gastrointestinal Problems," a session of the Section on Experimental Medicine and Therapeutics.

#### Gastroenterology and Proctology

Dr. Sidney M. Copland, Dayton, presented "Modern Treatment of Pruritus Ani," in a joint session of the Section on Gastroenterology and the Section on Proctology.

Dr. Rupert B. Turnbull, Cleveland, was moderator of a "Panel Discussion on the Rehabilitation of Patients with Intestinal Stomas," presented before the Section on Proctology.

Dr. Charles Brown, Cleveland, was named assistant representative to the Scientific Exhibit from the Section on Gastroenterology.

#### General Surgery

Dr. Donald M. Glover, Cleveland, was alternate delegate for the Section on General Surgery.

Dr. George Crile, Jr., Cleveland, discussed "Simple Mastectomy," in a "Symposium on Breast Cancer," before the Section on General Surgery, and participated in a panel discussion on the same subject.

Dr. Stanley Hoerr, Cleveland, was named secretary of the Section on General Surgery.

#### Internal Medicine

Dr. James V. Warren, Columbus, was chairman of the Section on Internal Medicine, and gave an address entitled "The Training of the Internist Today and Tomorrow."

Dr. William J. Cleary, Youngstown, was co-author of a paper entitled "A Study of Diabetes Mellitus in Patients with Gout," presented before the Section on Internal Medicine.

#### Ophthalmology

Dr. Edward H. Bloch, Cleveland, participated in a panel discussion on Microcirculation before a meeting of the Association for Research in Ophthalmology, Inc.

Dr. Elmer J. Ballintine, Cleveland, opened discussion on a paper entitled "A Study on Provocative Tests for Angle-Closure Glaucoma," presented before the Section on Ophthalmology.

#### Orthopedic Surgery

Dr. George S. Phalen, Cleveland, was secretary of the Section on Orthopedic Surgery.

Dr. Charles M. Evarts, Cleveland, presented a

paper entitled "Diagnosis and Treatment of Fat Embolism," before the Section on Orthopedic Surgery.

Dr. Karl S. Alfred, Cleveland, opened discussion on a paper entitled "Recurrent Fractures of the Forearm in Children," before the Section on Orthopedic Surgery.

Dr. E. L. Mollin, Akron, opened discussion on a paper entitled "Pin Fixation for Fractures of the Os Calcis," before the Section on Orthopedic Surgery.

#### Pathology and Physiology

Dr. J. Beach Hazard, Cleveland, was assistant secretary of the Section on Pathology and Physiology before the meeting and was named secretary for the coming year.

Dr. William Sinclair, Cleveland, was named assistant secretary of the Section on Pathology and Physiology.

#### Pediatrics

The Committee of the Council on Postgraduate Programs of the Section on Pediatrics, includes Dr. A. Ashley Weech, Cincinnati, chief editor, *American Journal of Diseases of Children*, ex officio.

#### Physical Medicine

Dr. Walter J. Zeiter, Cleveland, was delegate for the Section on Physical Medicine to the House of Delegates.

Dr. William C. Earl, Columbus, was representative of the Section on Physical Medicine to the Scientific Exhibit.

Dr. Ernest W. Johnson, and Dr. Anthony N. Pan-nozzo, Columbus, were authors of a paper entitled "Management of Shoulder-Hand Syndrome," presented before the Section on Physical Medicine.

#### Preventive Medicine

Dr. Paul A. Davis, Akron, was representative for the Section on Preventive Medicine to the Scientific Exhibit.

#### MOTION PICTURES

In the symposium of motion pictures, in some instances authors were present to introduce or discuss their films. Following are individual physicians or teams from Ohio who sponsored motion pictures.

Leon Goldman, M. D., Robert Wilson, M. D., John Ingleman, M. D., and Peter Hornby, Cincinnati, sponsored the motion picture, "Laser-Beam Therapy."

Drs. Charles H. Brown and Thomas F. Nikolai, Cleveland, sponsored the motion picture, "Percutaneous Liver Biopsy with Vim-Silverman and Menghini Needles."

Drs. Ernest W. Johnson and Robert J. Duran, Columbus, sponsored the motion picture, "Carpal Tunnel Syndrome."

Dr. Wesley Furste, Columbus, sponsored the motion picture, "A Look at Tetanus Prophylaxis." This was a premiere showing of the picture.

Dr. Chester C. Winter, Columbus, sponsored the motion picture, "Priapism: Surgical Treatment."

Dr. Austin B. Chinn, Cleveland, was one of the



discussants for a motion picture entitled "The Critical Decades," sponsored by the U. S. Public Health Service Gerontology Branch.

### THE SCIENTIFIC EXHIBITS

Dr. Joseph F. Tomashefski, Columbus, was moderator and one of the demonstrators in an exhibit entitled "Cyanosis — Carbon Dioxide Retention, Diagnosis and Treatment," a feature of the Special Exhibit on Pulmonary Function sponsored by the Section on Diseases of the Chest.

Dr. Leonard P. Cassamo, Youngstown, as a Fellow of the American College of Cardiology, participated in the Screening Examinations for Physicians.

Dr. Ralph G. Carothers, Cincinnati, is chairman emeritus of the Special Exhibit on Fractures.

Dr. John C. Schmerge, Cincinnati, was a demonstrator in the Special Exhibit on Fractures.

Drs. Norman O. Rothermich, Vol K. Philips and Waldemar Bergen, The Columbus Medical Center and Ohio State University, sponsored the exhibit, "Three-Year Clinical Evaluation of an Antirheumatic Agent," in the Exhibit Symposium on Arthritis and Rheumatism.

Dr. Henry Seeler, Dayton, was co-sponsor of an exhibit entitled "Step Toward Survival: A New Resuscitator Valve," in the Section on Anesthesiology.

Leon Goldman, M. D., Peter Hornby, Robert Wilson, M. D., and Robert Meyer, Children's Hospital Research Foundation, Cincinnati, sponsored the exhibit, "Laser Radiation of Various Tumors of Man," in the Section on Dermatology.

Drs. G. B. Stansell, F. M. Douglass and R. M. Glad, Maumee Valley Hospital, Toledo, sponsored the exhibit, "The Effect of Hyperbaric Oxygen on Anaerobic and Aerobic Infections," in the Section on Experimental Medicine and Therapeutics.

Drs. William M. Michener, Richard G. Farmer, and Charles H. Brown, Cleveland Clinic, were sponsors of an exhibit, "Ulcerative Colitis in Children," in the Section on Gastroenterology. A similar exhibit won the Gold Award in Original Investigation at the 1965 OSMA Annual Meeting.

Luis L. Gonzalez, M. D., Jerome F. Wiot, M. D., Charles Olinger, M. D., and Richard L. Clark, Veterans Administration Hospital and University of Cincinnati College of Medicine, Cincinnati, sponsored the exhibit, "Four-Vessel Cerebral Arteriography," in the Section on General Surgery.

Drs. Robert E. Hermann and Stanley O. Hoerr, Cleveland Clinic Foundation, sponsored the exhibit, "Operative Cholangiography — The Case for Its Routine Use," in the Section on General Surgery. A similar exhibit won the Bronze Award in the field of teaching at the 1964 OSMA Annual Meeting.

Dr. Paul E. McGuff, University of Cincinnati College of Medicine and Children's Hospital Research

### The Journal Will Publish Medicare Analysis

As this issue of *The Journal* went to press, Senate and House conference committee members were meeting to adjudicate the differences between Senate-passed and House-passed versions of the Medicare Bill, H. R. 6675.

It is expected that an agreed version will be reached within a matter of days.

Just as soon as the final form of the bill is available, an analysis of its contents will be published in *The Journal* for the information of OSMA members.

Foundation, Cincinnati, sponsored the exhibit, "Laser — A Surgical Tool," in the Section on General Surgery.

Drs. F. W. Rhineland, R. S. Phillips, W. M. Steel and J. C. Beer, Western Reserve University School of Medicine and Cleveland Metropolitan General Hospital, sponsored the exhibit, "Stereoscopic Microangiography in Bone Repair," in the Section on Orthopedic Surgery. This exhibit was awarded a Certificate of Merit as outstanding in its section.

Drs. Emmerich von Haam and Thomas D. Stevenson, Ohio State University, Columbus, sponsored the exhibit, "Demonstration of Malignant Cells in the Peripheral Blood," in the Section on Pathology and Physiology.

Dr. Daniel J. Hanson, Mercy Hospital, Toledo, sponsored the exhibit, "Rapid Serum Test for Phenylketonuria," in the Section on Pathology and Physiology.


H. William Porterfield, M. D., and Robert Stimper, Children's Hospital, Columbus, and Hearing and Speech Center of Columbus and Central Ohio, sponsored the exhibit, "Hypernasal Speech in Cleft-Palate and Non-Cleft-Palate Patients," in the Section on Pediatrics. A similar exhibit won the gold award for original investigation at the 1964 Annual Meeting of the Ohio State Medical Association.

Dr. Chester C. Winter, Ohio State University Medical Center, Columbus, sponsored the exhibit, "Priapism: Surgical Management," in the Section on Urology.

Drs. Lester Persky, Stephen A. Mahoney and William E. Forsythe, University Hospitals of Cleveland, sponsored the exhibit, "Pyelonephritis in Childhood," in the Section on Urology.

The Ohio State University College of Medicine has been awarded a \$383,370 grant from the U. S. Public Health Service for a training program in pharmacology, to assist graduate students in preparing for careers in pharmacology.

# Outstanding Scientific Exhibits At OSMA Annual Meeting

 OF THE 34 Scientific and Educational Exhibits presented at the 1965 Annual Meeting of the Ohio State Medical Association, several were selected as outstanding and their sponsors were recognized with certificates, engraved plaques of metal mounted on wood, plus monetary awards. Following are brief descriptions of two of these outstanding exhibits with photographs on the facing page.

\* \* \*

## Exhibit on Colitis in Children Wins One of Two Gold Awards

Gold Award winner in the field of original investigation at the 1965 OSMA Annual Meeting was the exhibit entitled "Ulcerative Colitis in Children," sponsored by the following team from the Cleveland Clinic Foundation: Dr. William M. Michener, Dr. Richard G. Farmer and Dr. Charles H. Brown.

(See facing page for photograph of the exhibit.)

The sponsors of this exhibit were presented a certificate, an engraved plaque and a monetary award.

Despite the fact that ulcerative colitis in children seems to be increasing in incidence, the literature indicates a comparative lack of research in this field and a lack of emphasis on its importance.

The exhibit reported the experience of the clinic in the diagnosis and treatment, both medical and surgical, of 108 children with ulcerative colitis, during the past 12 years.

A detailed analysis of the presenting complaints and diagnostic problems was portrayed with charts and photographs. The Medical program used to treat patients was outlined with special reference to the results obtained with the use of ACTH, oral and topical steroids (retention enemas).

The results of the program were shown both in tabular form and by means of photographs of patients, and the indications for surgical intervention.

Indications for surgery, the type of surgical procedure, and the results were listed for 31 patients. Photographs of patients and of surgical specimens, together with x-rays were used to illustrate procedure.

In the exhibit, emphasis was made on early diagnosis, prolonged medical therapy and surgical intervention when indicated.

### National Showing of Exhibit

The same team sponsored a similar exhibit on "Ulcerative Colitis in Children" at the Annual Con-

vention of the American Medical Association in New York City, June 20-24.

The Scientific Exhibit of the AMA was housed in the New York Coliseum. The Colitis exhibit was in the Section on Gastroenterology.

## Exhibit on Lymphatic Flow Wins Honors in Teaching Field

The Gold Award winner in the teaching field at the 1965 Annual Meeting was the exhibit entitled "Lymphangiographic Evaluation of Lymphatic Flow and Lymphedema," sponsored by a team from the Cleveland Clinic Foundation. On the team were Dr. Edward Buonocore, Dr. Jess R. Young, Dr. Victor G. deWolfe and Dr. Edwin G. Beven.

(See facing page for photograph of the exhibit.)

The exhibit demonstrated an advance from procedure of the past in which the interest of the clinician was focused on the roentgenographic analysis of the lymph nodes themselves. The exhibit stressed the value of lymphangiography in determining the course of lymphatic fluid flow and the competency of the lymphatic vascular system. The presentation was based on clinical experience of the sponsors and some 150 lymphangiograms made at the hospital.

The concept of vascular insufficiency of the lymphatic system and its correlation with the variability of the clinical course was explained.

Lymphangiographic classification of lymphedema was presented in graphic form. The differentiation of primary lymphedema from secondary lymphedema was demonstrated.

Newly found examples of deranged lymphatic flow were presented. One example of derangement was the free collection of lymphatic fluid resulting from surgical transection of lymphatic vessels, which may lead to sepsis, lymphedema or urinary tract obstruction.

\* \* \*

Watch for coming issues of *The Journal* and additional description of exhibits judged outstanding at the 1965 OSMA Annual Meeting.



# The Gold Award Winning Exhibits



*This is the Gold Award winning exhibit in the field of original investigation entitled "Ulcerative Colitis in Children" as it was displayed at the 1965 OSMA Annual Meeting. Holding the plaque, center, is Dr. Richard D. Farmer, one of the sponsors. With him is Dr. Lawrence M. Mlecko, (left), Fellow in gastroenterology at the Cleveland Clinic Foundation, who helped man the exhibit, and Dr. Lawrence C. Meredith, chairman of the judging committee.*



*In the field of teaching, the Gold Award went to this exhibit entitled "Lymphangiographic Evaluation of Lymphatic Flow and Lymphedema," as it was shown at the OSMA Annual Meeting. The awarded plaque is attached to the upper center panel. Holding the certificate is Dr. Meredith.*

# Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Portsmouth  
Chairman, Publicity Committee

NEW YORK, New York, It's a Wonderful Town," a magazine writer once gushed. Certainly it is a wonderful town in which to hold a convention. Ask any doctor's wife who attended the 42nd Annual Convention of the Woman's Auxiliary to the American Medical Association at the Americana Hotel, June 20 to 24. There just weren't enough hours in the day to take advantage of it all (your reporter knows — she was there).

For the Ohio delegation, it was a particular source of satisfaction and pride. Mrs. William H. Evans of Youngstown, National Auxiliary President for 1964-65, conducted the business sessions with decorum and graciousness and on occasion a delightful touch of adroit wit. She presided at the two extraordinary luncheons with dignity and charm. She was the recipient of many honors. (We vote her, incidentally, Number One on the list of Best Dressed Women there.)

On behalf of the National Auxiliary, Mrs. Evans had the privilege of presenting to Dr. Raymond M. McKeown, president of AMA-ERF, a check in the amount of \$320,121.87 — the combined financial efforts of county auxiliaries throughout these United States for 1964-65. That's more, I realized with almost a shock, than a quarter of a million dollars! It established a new record and it was an increase of some \$14,000 over last year's contribution. A particularly proud moment for Dena Evans was the presentation of the plaque by Harold Russell, chairman of President Johnson's Committee on the Employment of the Handicapped. Dr. Henry A. Crawford, OSMA President, presented to Mrs. Evans a most unusual necklace — one made out of Buckeyes! Mrs. John D. Dickie, representing the Ohio Auxiliary, presented her with a beautiful silver bowl.

Another high moment for the Ohio delegation was the election of Mrs. Karl F. Ritter of Lima to a two-year term as a national director. Gerby Ritter has served three years as AMA-ERF chairman, four years as national Finance Secretary and this past year as Treasurer — an impressive record of national service. Ohio was to receive still another national recognition in the person of Mrs. John D. Dickie of Toledo, immediate past State President, who was appointed program chairman. She also served on the convention's Election and Tellers Committee.

Your reporter made the remark last year that it is no small feat to be in successful competition with 49 other states. The comment still holds — and so does Ohio! One more case in point: Out of six county auxiliaries singled out from all over the country for awards in AMA-ERF, two such awards were captured by Ohio counties. Hats off to Allen County (a "repeat" winner) and Tuscarawas County (home territory of our State President, Mrs. Herbert F. Van Epps of Dover).

## Tidbits from Convention

Mrs. Richard A. Sutter of St. Louis, Missouri, is the new National President . . . There are some 87,000 National Auxiliary members . . . There were approximately 1,000 doctors' wives registered at convention . . . 427 pre-teens and teen-agers took part in the exciting programs set up for them . . . Marge Dickie's report to National of Ohio activities stood as tall as any of them . . . The Ohio Breakfast at the Americana (Mary Louise Van Epps was hostess) witnessed the full complement of delegates and alternates, plus red carnations and Buckeye badges for Dr. Hudson . . . The 19 accredited delegates from our state were to be counted in full at each business session . . . Dena Evans' reception in her suite on Thursday afternoon provided plenty of — goodies . . .

Which reminds us that she was the recipient of a plaque from United Air Lines for over half a million miles of air travel . . . Not to be outdone by his wife, Dr. Evans was presented with a unique, hand-stitched plaque designating him "Member Extraordinaire," compliments of the Louisiana delegation . . . The double-tiered Speakers' Table at Tuesday's luncheon in the Trianon Ballroom of the Hilton Hotel was a sight to behold — as was the decorative theme of "Freedom Bells for Medicine," huge white liberty bells centering each table, gold ribbons at the side, and a gold "crown" topping it with the name of the respective states . . .

The Fashion Show at the Americana on Sunday afternoon is beyond description (fuller skirts are coming back, girls, and hemlines continue of varied lengths of brevity) . . . Sponsored by Coty Perfumes, the top American designers paraded a fabulous collection (laces, satins, brocades, velvets are "in," as are jeweled coats and something called a Swansdown

(Continued on Page 761)



coat and beads attached to sequins on formal attire and such outstanding designers as Adele Simpson, Ann Fogarty, Samuel Winston, Donald Brooks, Helen Lee, Ben Zuckerman, Norman Norell — to name just some of them — were making the doctors' wives of America goggle-eyed . . .

Dr. McKeown, president of AMA-ERF, announced the Foundation's newest project — the Institute for Bio-Medical Research. He said that eminent scientists were being recruited for the Institute's staff and that it was to engage in basic research into the living cell.

It is impossible, of course, to tell the whole, interesting National Convention story — which is an Experience. Your reporter can only highlight some of the events.

### From Here and There in Ohio

A member of the **Allen Auxiliary** was honored recently by the Lima chapter of the NAACP. Mrs. J. M. McBride was presented with the Human Rights Award for promoting such rights, particularly in her work at the Mizpah Mission. She was also named "Woman of the Year" at the Soroptomist Club's 26th anniversary dinner. This is the third time in relatively recent years that a doctor's wife in Lima has been singled out for that award. The other two honorees were: Mrs. Karl F. Ritter and Mrs. M. M. Sondheimer. Still another Allen County member, Mrs. F. D. Rodabaugh, was the recipient this year of a similar award in her community of Bluffton. Nice going — in community service and good public relations . . .

Past-presidents of the **Columbiana Auxiliary** were presented with charms at the group's annual "Rose Luncheon" at the Holiday House near Youngstown. Mrs. William J. Horgner made the presentations to Mrs. M. D. McCutcheon, the 1941 organizing president and originator of the Rose Luncheon; Mrs. C. W. DeWalt, Mrs. A. S. Fisher and Mrs. Charles Gerace. Mrs. Gerace, the outgoing president, handed over the gavel to the new president, Mrs. Wade Bacon. Guests at the luncheon included Mrs. Joseph Tandatnick, Mahoning Auxiliary president; Mrs. Duane Banks, Sixth District director, and Mrs. Paul Sauvageot, editor of the *Auxiliary News*. Miss Esther Hamilton, a columnist for the *Youngstown Vindicator*, was guest speaker.

A recent fund-raising project sponsored by the Cuyahoga County group was its annual Lilac Time luncheon, card party and style show, held in the Higbee Auditorium. The *piece de resistance* was the top prize hat designed and worn by Mrs. Robert H. McDonald — a chic bonnet made up of 75 one-dollar bills! Net result? A whopping \$640 — from the luncheon and the "Money Hat" (that was bought by the sister of another Auxiliary member). Imaginative action at its best!

The Lilac Time committee included: Mrs. George H. Curtis, chairman; Mrs. Henry A. Crawford, Mrs.

### National Auxiliary Is Honored For "Handicapped" Service

The Woman's Auxiliary to the American Medical Association was signally honored at its 42nd convention in New York June 21 when Mrs. William H. Evans, 1964-65 National President, was presented, on behalf of the Auxiliary, a plaque of commendation from Mr. Harold Russell, chairman of President Johnson's Committee on Employment of the Handicapped. Mrs. Evans had served this past year on that committee.

The plaque reads: "Citation for Exceptional Services . . . This award is gratefully conferred upon the Woman's Auxiliary of the American Medical Association — In recognition of its outstanding contribution through its many and varied programs in helping the nation's handicapped people to achieve rehabilitation and become self-sufficient through gainful employment . . . Signed — Harold Russell, Chairman, The President's Committee on the Employment of the Handicapped — Presented at New York City, June 21, 1965."

Earlier, Mr. Russell addressed the Auxiliary's House of Delegates, speaking on "New Frontiers for the Handicapped." He was introduced by Mrs. C. A. Colombi of Cuyahoga County, 1964-65 national chairman of Community Service. The closing words of Mr. Russell, himself an amputee and winner of an Oscar award, were particularly significant:

"It's not what you have lost but what you have left."

Robert Eiben, Mrs. James A. Gavin, Mrs. Joseph M. Kaplan, Mrs. Robert W. Kapp, Mrs. Fred R. Kelly, Mrs. Roscoe J. Kennedy, Mrs. Robert H. McDonald, Mrs. Howard J. Parkhurst, Mrs. Samuel J. Pastorelle, Mrs. George L. Sackett, Jr., Mrs. Penn G. Skillern and Mrs. Edward Wilkerson.

### Still on the Ohio Circuit

The **Fairfield Auxiliary** has a new set of officers, installed by Mrs. Carl Frye, 8th District Director. They include: Mrs. Robert Whetstone, president; Mrs. Gordon Snider, president-elect; Mrs. Kenneth Gaines, vice-president; Mrs. Paul McMullen, secretary and Mrs. David Sheidler, treasurer. The installation was held at a luncheon at the Hotel Lancaster. Mrs. Andrew Essman, outgoing president, conducted the business meeting and committee chairmen gave condensed reports of the year's activities. Mrs. Wilford Nusbaum was hostess for the occasion, assisted by Mrs. McMullen, Mrs. James Beesley, Mrs. Charles Clark and Mrs. Donald Nichols.

The *Cincinnati Post* and *Times-Star* recently gave

top billing to Mrs. John B. Toepfer, new president of the **Hamilton Auxiliary**, with a feature story in its "Women Today" column. Would that our local Auxiliary presidents could get that kind of fine publicity more often! Other new officers of the Hamilton group include: Mrs. Ben I. Friedman, president-elect; Mrs. Makoto Yamaguchi, vice-president; Mrs. Henry Wedig, Jr., recording-secretary; Mrs. Albert Zoss, corresponding-secretary; Mrs. Calvin F. Warner, Mrs. Robert S. Heidt and Mrs. George B. Haydon, directors. Mrs. Noble O. Fowler continues in her two-year term as treasurer.

A provocative Hamilton presentation was the Hobby Auction held in May at the Maple Ridge Lodge in Mt. Airy Forest. Paintings, sculpture, jewelry, needlework, garden products and gourmet pastries went on the auction block for the benefit of AMARERF. Box lunches were served under the trees preceding the auction. Mrs. Stephen P. Hogg served as luncheon chairman, assisted by Mrs. Nelson R. Cragg. Mrs. Albert H. DeGarmo and Mrs. Roger G. Giesel were hospitality co-chairmen, and the display of the hobby items belonged to the deft fingers of Mrs. Hilmer W. Neumann, Mrs. Ben I. Friedman and Mrs. James A. Wiseman. For all their efforts? A net profit of \$300. That's another example of what talent, initiative and hard work can do . . .

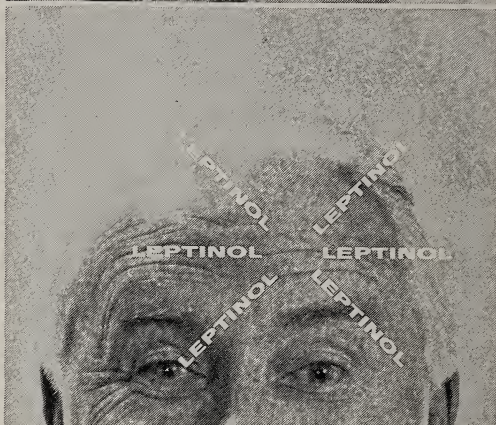
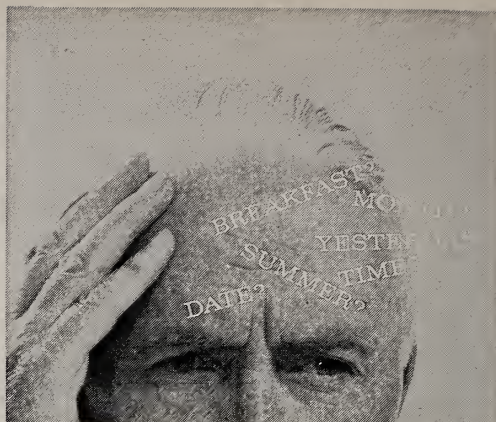
#### In the Toledo Times

Still another outstanding coverage in newspaper columns recently — *The Toledo Times* devoted more than a quarter page plus photograph to Mrs. John D. Dickie, immediate past state president. It was a fine and fitting tribute to Marge, of course; but of even more significance is the fact that such a write-up tells the Auxiliary story in a tremendously effective manner. There is nothing quite like it, publicitywise.

At its late May luncheon at the Buckeye Hotel in Uhrichsville, the Tuscarawas Auxiliary saluted Mrs. Herbert F. Van Epps, state president, and member of the local auxiliary. Mrs. Van Epps expressed her gratitude for the group's cooperation and many courtesies at the state convention. Mrs. E. R. Hammersley, president, presided at the business meeting. The \$200 realized from the Dr. Murray Banks' lecture has been earmarked for the health careers and nurses' loan funds. A white-elephant sale followed the meeting, the proceeds of which went to AMARERF. Mrs. E. L. Miller was chairman of the luncheon meeting, assisted by Mrs. R. J. Kuba, Mrs. A. A. Greenleaf and Mrs. R. E. Wolf.

Your reporter has many more items — believe it or not! But no more space. Look for yourselves in next month's issue.

New offices of the Stark County Tuberculosis and Health Association at 1300 Ferndale Road, N. W., in Canton, were dedicated with ceremonies on June 6. The group has served the area for some 56 years.



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# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*

— Justice Robert H. Jackson in AAA Supreme Court Case, 1942

## AMA MEETING SHOWS DELEGATES NEED TIME FOR HOMEWORK

Actions and statements by members of the AMA House of Delegates and some of the House Reference Committees' reports at the Annual Convention in New York City last June lead to the conclusion that members of the House need more time to do their homework.

Some of the testimony heard before reference committees and some of the reports of the committees clearly showed that delegates either had not read or else had misinterpreted the subjects they were discussing.

For example, the Ohio delegation, as directed by OSMA Council, submitted a resolution calling for House endorsement of the formation of an American Board of Family Practice. This was one of several similar resolutions.

The House Reference Committee on Medical Education and Hospitals recommended and the House approved referral of the resolution to the Council on Medical Education, claiming that adoption of the resolution would supercede the current procedure for establishing a board. Actually, the Ohio resolution did not call for the House to establish a board. It simply asked for House approval of a board, leaving the procedural matters entirely in the established and recognized channels.

The AMA House of Delegates would do well to adopt the 60-day deadline for resolutions adhered to by the OSMA House of Delegates. The OSMA deadline provides for presentation of resolutions, if circumstances warrant, after the deadline.

Having resolutions, reports of the AMA Board of Trustees and reports of the many councils and committees in the hands of AMA delegates well in advance of sessions would indeed provide ample and necessary time for the extensive homework a delegate needs. He then could go to these sessions well-informed as to the actions and decisions he faces as a member of the tremendously important AMA House of Delegates.

## DeBAKEY REPORT IS HIDDEN BALL PLAY FOR SOCIALISTS

With almost all of medicine's attention, and the public's attention as well, focused on medicare, legislation resulting from the report of the President's Commission on Heart Disease, Cancer and Stroke might well be dubbed a "hidden ball play" for those interests who seek to nationalize American medicine.

On recommendation of the Commission, headed by Dr. Michael DeBakey, an AMA Distinguished Service Award recipient, the proposed legislation, Senate Bill 596 and House Resolution 3140, would establish a significantly large number of medical diagnostic and treatment centers throughout the entire nation.

Establishment of these centers would be fatally dangerous to our system of medical care. This would place the government directly into the practice of medicine, with Federally salaried physicians and ancillary personnel providing medical services.

The report of the commission speaks blithely of establishing 150 "heart stations" in the nation, co-ordinated statewide laboratory facilities in every state, 30 new "stroke stations," 40 new rehabilitation centers, and other such items.

What the report, in its two thick volumes, fails to mention is (1) there are excellent medical facilities already available in all parts of the nation; (2) the professional staffing and operation of such centers would be accomplished only by "blank check" raids on existing centers, such as medical schools, hospitals and related facilities, and (3) the establishment of such centers would be only one short step from federally owned and operated centers to cover all diseases and to provide diagnosis and treatment for all persons, regardless of need.

And, to cap it all off, the Commission first decided where it was going, then set out to justify its destination. This cannot be defined as "scientific investigation."

Dr. William J. Lewis, Dayton, spoke on the subject of medicare at a meeting of the Oakwood Women's Republican Club.

## Scientific Assembly of OAGP Scheduled in Toledo

Officers of the Ohio Academy of General Practice have invited all physicians, including residents and interns, to attend the 15th Annual Scientific Assembly of OAGP to be held at the Commodore Perry Hotel, Toledo, Tuesday, August 17 to Thursday, August 19.

Registration begins at noon on Tuesday, August 17, with sessions on Tuesday afternoon through Thursday morning.

### Tuesday Afternoon, August 17 (Registration opens at Noon)

**Complete Neurological Examination** — Dr. Robert C. Atkinson, Columbus.

**Office Ophthalmology the Family Doctor Should Practice** — Dr. Malcolm A. McCannel, Minneapolis, Minnesota.

**Gout** — Dr. Richard T. Smith, Philadelphia, Pa.

**The Family Doctor and the Computer** — Otto H. Schmitt, Ph. D., Minneapolis, Minn.

### Wednesday Morning, August 18

**Breakfast Session 1: Medical Care for Adolescents** — Dr. Thomas E. Cone, Boston.

**Breakfast Session 2: Accentuating the Positive in Rheumatology** — Dr. Smith.

**Breakfast Session 3: Bifocals, Bruises and Bugs**, Dr. Malcolm A. McCannel.

**D & C Fumbles** — Dr. Buford Word, Birmingham, Alabama.

**Functional Uterine Bleeding** — Dr. Robert B. Greenblatt, Augusta, Ga.

**Shocking News About Shock** — Dr. Philip Thorek, Chicago.

**Hiatus Hernia** — Dr. W. Arnold McAlpine, Toledo.

### Noon Luncheon Sessions

**Luncheon Session 1: The Acute Abdomen** — Dr. Thorek.

Breakfast and luncheon sessions at the OAGP Scientific Assembly will be limited in attendance and arrangements to attend these features of the program should be made in advance with Robert Wilson, Executive Secretary, OAGP, 4075 N. High Street, Columbus 43214.

**Luncheon Session 2: Trauma** — Dr. John A. Siegling, Charleston, S. C.

**Luncheon Session 3: The Tall Girl Syndrome** — Dr. Robert B. Greenblatt.

**Luncheon Session 4: Diagnosis and Treatment of Thrombophlebitis and Its Complications** — Dr. Victor G. deWolfe, Cleveland.

**Luncheon Session 5: Cancer of the Stomach** — Dr. Gordon McNeer, New York City.

### Wednesday Afternoon

**New Drugs of Past Two Years** — Arthur Tye, Ph. D., Columbus.

**The Diagnosis and Management of Malignant Melanoma** — Dr. McNeer.

**Pitfalls of Fracture Care** — Dr. Siegling.

**Arterial Embolism: Diagnosis and Treatment** — Dr. DeWolfe.

### Wednesday Evening

**Emotional Problems of the Adolescent** — Dr. Beverly T. Mead, Omaha, Nebraska.

### Thursday Morning, August 19

**Adolescent Medicine** — Dr. Cone.

**Newer Concepts in the Management of Obesity** — Theodore G. Duncan, Philadelphia.

**Recent Advances and Changes in Treatment of Diabetes** — Dr. Leo P. Krall, Boston.

**Nutrition in Teenagers** — Dr. Willard A. Krehl, Iowa City.

**Anxiety and Depression** — Dr. Mead.

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# Ad Astra

**Frank Monroe Casto, M.D.,** La Jolla, Calif.; Ohio Medical University, Columbus, 1900; aged 89; died April 25; former member of the Ohio State Medical Association. A former resident of Cleveland, Dr. Casto left the state many years ago.

**Walter Corey Corns, M.D.,** Columbus Grove; Cleveland-Pulte Medical College, 1911; aged 88; died June 9; former member of the Ohio State Medical Association. Dr. Corns served virtually all of his professional career of many years in the Columbus Grove area. He was a member of the Methodist Church, a 50-year member of the Masonic Lodge, a 60-year member of the Elks Lodge and a veteran of the Spanish-American War. A daughter survives.

**William Edward Dean, M.D.,** Covington, Ky.; Eclectic Medical College, Cincinnati, 1923; aged 70; died April 19. A practitioner for many years in the Covington area, Dr. Dean was known to physicians in Southwestern Ohio.

**Bernice Adele Fleek, M.D.,** Cambridge Springs, Pennsylvania (formerly of Ashtabula); Hahnemann Medical College and Hospital, Chicago, 1913; aged 89; died June 7; member of the Ohio State Medical Association and the American Medical Association. A practicing physician for some 40 years in Ashtabula, Dr. Fleek retired about 10 years ago and moved to Pennsylvania to stay with relatives. Recently she resided at the Presbyterian Home in Cambridge Springs. A nephew survives.

**Robert Edwin Hall, M.D.,** Canton; Western Reserve University School of Medicine, 1921; aged 69; died June 5; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Canton for many years and former medical examiner for the Timken Roller Bearing Company in recent years, Dr. Hall was living in retirement. Affiliations included membership in the Masonic Lodge, the Christian Church, the Audubon Society and the International Fellowship Club. Survivors include his widow and a son.

**Carrie Alice Herring, M.D.,** Hubbard (formerly of Akron); University of Cincinnati College of Medicine, 1917; aged 74; died June 16; member of the Ohio State Medical Association and the American Medical Association. Dr. Herring retired in 1942 and moved to Hubbard after practicing for about 40 years in Akron. In Akron she was a member of the Baptist Church, the Historical Society, the Business Women's Club and the Association of University Women. A sister survives.

**William Joseph Hrutkay, M.D.,** Yolyn, W. Va. (formerly of Cleveland); St. Louis University School of Medicine, 1927; aged 63; died June 14. A physician for some years ago in Cleveland, Dr. Hrutkay was associated with Lutheran Hospital. His mother and a sister survive.

**Henry Klinzing, M.D.,** Delaware; Jefferson Medical College of Philadelphia, 1908; aged 83; died April 9. A former practitioner in Pennsylvania, Dr. Klinzing was a 50-year member of the Allegheny Medical Society of that state. He was living in retirement in Delaware. Survivors include a daughter, a sister and a brother.

**Gustav Kollmann, M.D.,** Cincinnati; Medical Faculty of the University of Vienna, 1917; aged 70; member of the Ohio State Medical Association and the American Medical Association. Educated in Austria and a former practitioner in Vienna, Dr. Kollmann came to this country in the late 1930's. His practice was centered in the Oakley area of Cincinnati. Survivors include his widow, two daughters and a son.

**Louis Black Lee, M.D.,** Tiltonsville; Ohio State University College of Medicine, 1933; aged 57; died June 24; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A physician in the Tiltonsville - Martins Ferry area for about 30 years, Dr. Lee was engaged in general practice and surgery. He was a charter member of the local Lions Club, an honorary member of the local volunteer fire department, a member of the Masonic Lodge and physician for the consolidated high school teams. Dr. Charles V. Lee of Martins Ferry is a brother. Also surviving are his widow, two daughters, three sons, and two other brothers.

**Reuben Ralph Maier, M.D.,** Cleveland; Western Reserve University School of Medicine, 1932; aged 58; died June 9; member of the Ohio State Medical Association, the American Medical Association, American College of Obstetricians and Gynecologists; Fellow of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology; member of the OSMa Committee on Maternal Health. A practicing physician and surgeon in Cleveland, Dr. Maier was associated with several hospitals. Among survivors are his widow and a daughter.

**Roscoe R. Miller, M.D.,** Fort Lauderdale, Fla.; Western Reserve University School of Medicine, 1929;

aged 61; died May 30; former member of the Ohio State Medical Association and the American Medical Association. A former practitioner in the Cleveland area, Dr. Miller was making his home in Florida.

**John Francis Ralston, M.D.**, Hendersonville, North Carolina (formerly of Cleveland); University of Illinois College of Medicine, 1925; aged 68; died June 21. A career Public Health Service medical officer, Dr. Ralston was for a number of years chief of the U. S. Public Health Service outpatient clinic at Cleveland. He retired in 1960. Survivors include his widow and several grandchildren.

**Samuel Reingold, M.D.**, Cincinnati; University of Cincinnati College of Medicine, 1936; aged 58; died June 15; member of the Ohio State Medical Association and the American Medical Association. A native of Poland, Dr. Reingold lived in Tel Aviv until he came to this country in the late 1920's. A practitioner of long standing in Cincinnati, he specialized in internal medicine. Affiliations included membership in the Temple and the Zionist Order of America. The survivors include his widow, a son, two brothers, and a sister.

**James Andrew Riley, M.D.**, Cleveland; Howard University College of Medicine, 1930; aged 63; died June 25; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. An earlier resident of Cleveland, Dr. Riley returned there to practice after completing his medical training. Among affiliations, he was a member of the Baptist Church. Survivors include his widow, two sons, a daughter and his father.

**Adolf Wolff, M.D.**, Chillicothe; University of Heidelberg Faculty of Medicine, 1921; aged 70; died June 21; member of the Ohio State Medical Association, the American Medical Association and the American Diabetes Association. Dr. Wolff was educated in Europe and trained there in internal medicine. His practice in the Chillicothe area extended over 24 years. His widow and a son survive.

**Harry Edward Wolk, M.D.**, Miami Beach, Fla.; Friedrich-Wilhelms University Faculty of Medicine, 1933; aged 59; died June 11; former member of the Ohio State Medical Association and the American Medical Association; member of the American College of Obstetricians and Gynecologists. Dr. Wolk practiced in the Cleveland area for about 12 years before moving to Florida some 10 years ago. Surviving are his widow, two daughters, a son and two sisters.

**Jess Judson Woodworth, Jr., M.D.**, Cleveland; Hahnemann Medical College and Hospital of Philadelphia, 1941; aged 51; died June 29; former member of the Ohio State Medical Association and the American Medical Association; member of the American College of Obstetricians and Gynecologists. After completing his internship, Dr. Woodworth entered military service with the Navy during World War II and attained the rank of lieutenant commander in the Medical Corps. He returned to the Cleveland area to practice at the end of the war. He was a member of the Masonic Lodge. Survivors include his widow, three daughters and his father.

## COMING MEETINGS

### Ohio State Medical Association:

- 1966 Annual Meeting, Cleveland, Week of May 22.
- 1967 Annual Meeting, Columbus, Week of May 14.
- 1968 Annual Meeting, Cincinnati, Week of May 12.

### American Medical Association:

- 1965 Clinical Convention, Philadelphia, Nov. 28-Dec. 1.
- 1966 Annual Convention, Chicago, June 26-30.

The American College of Physicians, Fall Meeting, October 7-9, Deauville Hotel, Miami Beach, Fla.

American College of Obstetricians and Gynecologists, District V, District Conference, October 28-30, Cleveland; also conference on neonatal nursing.

Ohio Academy of General Practice, 15th Annual Scientific Assembly, Toledo, August 17-19.

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# Group of Doctors of Guernsey County



*This group of physicians of Guernsey County posed for a picture at a recent meeting. One of the 88 County Medical Societies in Ohio, the Guernsey County Medical Society is in the 25-to-50 membership size. Shown, from left to right, are: FRONT ROW: M. C. McCuskey, M.D.; James A. Toland, M.D.; W. L. Denny, M.D.; Clarence Apel, M.D., and James Boyle, M.D. SECOND ROW: Dayle O. Snyder, M.D., Society secretary-treasurer; Miroslaw Hnatiuk, M.D., Society president; Darrell J. Smith M.D.; Thomas Swan, M.D.; and John Haun, M.D. THIRD ROW: Howard Miller, M.D.; A. C. Smith, M.D., Society vice-president; Manuel Diaz, M.D.; George Wyatt, M.D., and Jack Knapp, M.D.*

## Activities of County Societies . . .

### BELMONT

The Belmont County Medical Society with the Auxiliary held a regular dinner meeting and program at the Belmont Hills Country Club on June 17.

### MAHONING

The Mahoning County Medical Society held the second annual dinner-meeting with the clergy, on May 18. Speaker was Rev. Thomas J. O'Donnell, S. J., regent of Georgetown University Schools of Medicine and Nursing, who spoke on "The Use of Oral Progestational Drugs and Contraception." The

speaker was introduced by Dr. William J. Cleary, chairman of the Medicine and Religion Committee.

Dr. Irwin W. Bean of Regina, Canada, was the speaker at the June 15 meeting of the Mahoning County Medical Society. He spoke on "Government Control of Medicine in Saskatchewan, Past, Present and Future." Dr. Bean was president of the College of General Practice of Canada at the time of the government take-over in Saskatchewan. He was introduced by Dr. Joseph W. Tandatnick, program chairman.

Dr. Clifford L. Kiehn, Cleveland, is the new president of the American Association of Plastic Surgeons and chairman of the American Board of Plastic Surgeons.

## California Encephalitis Infection Revealed Among Ohio Patients

Recent epidemiological and laboratory investigations by the Ohio Department of Health have revealed the occurrence in Ohio of 36 cases of illness apparently due to California encephalitis virus (CEV) infection. This announcement was made by Dr. Calvin B. Spencer, acting chief of the Division of Communicable Diseases of the Ohio Department of Health, who urged full and complete cooperation of health commissioners, practicing physicians, and clinic and hospital personnel in statewide surveillance efforts.

The clinical signs and symptoms were severe and typical of central nervous system (CNS) involvement.

The onset dates ranged between the first of July and the sixth of October. The places of residence were distributed in 20 counties throughout Ohio, and the probable exposure sites were similarly well distributed. Fourteen of the 34 cases occurring in 1964 gave history of extended outdoor activity, camping, fishing, visiting away from home; twelve gave no history of extended outside activity or visiting away from home, but of these 12, ten resided in rural

areas. A reliable history is not yet available for the remaining 8 cases.

The ages varied from 4 to 29, only 3 being over 15 years, with one fatality, a child, age 6 years.

From the cases thus far studied in Ohio, CEV infection appears to produce profound clinical illness, principally in children. It is associated with outdoor activity or close proximity of residence to ideal mosquito habitat. The mortality rate is relatively low, considering the severity of the clinical course.

The probability of the existence of unrecognized subacute, subclinical cases must not be overlooked.

Epidemiologically certain characteristics were noted:

1. The clinical cases occurred in children or majority of young adults.
2. While this infection caused severe systemic illness, with CNS focus, there were few if any cases with signs of residual damage, and the mortality rate was quite low.
3. The cases were widely distributed throughout the state.

The California encephalitis group virus is known to occur in a number of small mammals. Mosquitos have been proved capable of transmitting the virus. The infection in humans is accidental and occasional as is true of other arthropod-borne viruses, and occurs

when abnormal capillary  
permeability and fragility are  
factors in

**bleeding**

in such conditions as:

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**purpura** (nonthrombocytopenic)

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(Encephalitis — Continued)

seasonally, the recently found cases having occurred during the summer and fall.

The Ohio Department of Health is instituting field investigations of insects to determine the vectors responsible for virus transmission and of small mammals in selected areas where transmission of California encephalitis virus was probable in 1964, and will do follow-up studies in areas from which cases may be reported in 1965. This study of mammals is to determine the species which may serve as reservoirs or that may be clinically affected and serve as indicators of virus activity.

The full and complete cooperation of Health Commissioners, physicians, and medical clinics or hospitals in this surveillance effort is urgently requested, especially the prompt reporting of cases of encephalitis or suspect encephalitis with early symptoms of fever, headache, and often vague signs of neurological disturbance. In the absence of signs of nervous system involvement, a variety of other symptoms, singly or in combination, such as conjunctivitis, nasopharyngitis, intestinal or abdominal pain may be noted.

Dr. Spencer advised that whole blood specimens, 5 to 10 cc, should be taken as soon as possible and forwarded to the Ohio Department of Health Laboratory, 382 West 10th Avenue, Columbus, Ohio, for

serologic testing, together with a brief summary of the case history, giving name and age, address, and the tentative diagnosis. No additive or preservative should be used. A second blood specimen should be forwarded two to three weeks later. If the case results in death, fresh tissue specimens should be taken from several areas of the brain, and brain stem, prior to embalming, and immediately frozen in dry ice for forwarding to the ODH Laboratory (address above), for pathological and virological examination.

All specimens should be sent by the most expeditious means. Blood specimens may be sent by mail, Railway Express, United Parcel Service, or, if convenient, by messenger.

Tissue specimens, frozen, should be delivered by messenger, if possible, otherwise they may be forwarded, special attention, by Railway Express or United Parcel Service, and with notification by telephone to the ODH Laboratory, Code 614, AX 9-2163 or 469-2280, giving time of departure and approximate time of arrival in Columbus. This will assure prompt delivery to the Laboratory of specimens in satisfactory condition for examination.

Much effort, involving many areas of endeavor must be applied to this problem to determine the factors basic to effective control of the various arthropod-borne virus diseases.

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Delegate to take office Jan. 1, 1966, Frederick P. Osgood, Toledo; alternate, Robert N. Smith, Toledo.

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**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.

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**HAMILTON**—John J. Cranley, President, 320 Broadway, Cincinnati 45202; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

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**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.

**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, 29 East Wood Street, Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

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**AUGLAIZE**—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville. Called meetings.

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**MARION**—James A. McGlew, President, 399 E. Church St., Marion; Lester E. Wall, Secretary, 317 S. Main St., Marion. 1st Tuesday, monthly.

**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.

**SENECA**—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.

**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.

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**OTTAWA**—Robert Reeves, Port Clinton Road, Oak Harbor; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.

**PUTNAM**—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Luginbuhl, Secretary, Pandora. 1st Tuesday monthly.

**SANDUSKY**—J. L. Zimmerman, President, Memorial Hospital, Fremont; Mrs. Fatsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.

**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

**WOOD**—Louis P. Baldoni, President, 195 E. Broadway, Perrysburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

## Fifth District

Councilor: P. John Robeche, Cleveland 44106  
10525 Carnegie Ave.

**ASHTABULA**—Harmon O. Tidd, President, 362 Rogers Place, Ashtabula; William F. Doran, Secretary, 241 Mill St., Conneaut. 2nd Tuesday, monthly.

**CUYAHOGA**—William F. Boukalik, President, 20030 Scottsdale Blvd., Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 6.

**GEAUGA**—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

## Sixth District

Councilor: Edwin R. Westbrook, Warren 44481  
438 North Park Ave.

**COLUMBIANA**—Peter Cibula, President, 356 E. Lincoln Way, Lisbon; Ernst P. Schaefer, Secretary, 412 N. Lincoln Ave., Salem. 3rd Tuesday, monthly.

**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.

**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARK**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., N.W., Canton 44702. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

## Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry 43935  
30 S. 4th St.

**BELMONT**—Robert N. Lewis, President, 100 W. Main Street, St. Clairsville; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.

**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.

**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

**MONROE**—Byron Gillespie, Secretary, S. Main St., Woodsfield.

**TUSCARAWAS**—S. H. Winston, President, 658 Boulevard, Dover; G. W. Johnston, Secretary, 658 Boulevard, Dover. 2nd Thursday, monthly.

## Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705  
2236 Maple Ave.

**ATHENS**—Robert E. Main, President, 400 East State Street, Athens; Lester A. Hamilton, Secretary, 400 East State Street, Athens. 2nd Tuesday at noon, monthly.

**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hodsdon, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Senecaville; Dayle O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.

**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

**NOBLE**—F. M. Cox, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.

**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.

**WASHINGTON**—Donald Fleming, President, Vincent; Archbold M. Jones, Jr., Secretary, 326 Third St., Marietta.

## Ninth District

Councilor: George N. Spears, Ironton 45638  
2213 S. 9th St.

**GALLIA**—Leonard Harris, President, Holzer Clinic, Gallipolis; James A. Kemp, Secretary, Holzer-Clinic, Gallipolis. Quarterly meetings at called times.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

**JACKSON**—A. R. Hambrick, President, Wellston; John C. MacLennan, Secretary, Oak Hill. Meeting date varies.

**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

**MEigs**—Selim J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once monthly.

**PIKE**—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.

**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

## Tenth District

Councilor: Richard L. Fulton, Columbus 43212  
1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

**FAYETTE**—Thomas J. Hancock, President, 220 E. Market St., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 2nd Friday, monthly.

**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

**ROSS**—Paul F. MacCarter, President, 60 Central Center, Chillicothe; Richard L. Counts, Secretary, 56 E. Second St., Chillicothe.

**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

## Eleventh District

Councilor: William R. Schultz, Wooster 44691  
1749 Cleveland Road

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Clem Chalfant, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.

**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P. O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

**HOLMES**—Owen F. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.

**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; Mrs. C. Ruth Zealley, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.

**MEDINA**—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Stanley L. Brody, President, 327 Park Ave. W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.



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**INDICATIONS:** Mild to moderate hypertension. **CAUTIONS:** Severe mental depression has appeared in a small percentage of patients, primarily in a dosage above 1 mg daily. Usually the patient had a preexisting, incipient, endogenous depression which was unmasked or accentuated by reserpine. When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required. Daily dosage above 0.25 mg is contraindicated in patients with a history of mental depression or peptic ulcer; use lower doses with caution. Not recommended in aortic insufficiency. Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to reverse hypotension and/or bradycardia. Use cautiously with digitalis, quinidine, or guanethidine. When patients on reserpine receive electroshock therapy, use lower milliamperage and a shorter duration of stimulus initially. Shock therapy within 7 days after giving the drug is hazardous. **SIDE EFFECTS:** Occasional: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation. Rare: anorexia, headache, bizarre dreams, nausea, dizziness. Nasal congestion and increased tracheobronchial secretions may occur in newborn babies of mothers treated with reserpine. **AVERAGE DOSAGE:** *Initial*—Two 0.25-mg tablets p.c. daily. *Maintenance*—Reduce daily dosage to 0.25 mg or less p.c. **SUPPLIED:** *Tablets*, 0.25 mg (white, scored) and 0.1 mg (white).

CIBA Pharmaceutical Company  
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**C I B A**

## Court Rules on Expert Testimony By Physician-Defendant

Physicians and their legal advisors should be alert with regard to a May 12, 1965, decision of the Ohio Supreme Court which says in effect that:

In a malpractice action, expert testimony may be elicited from a physician-defendant called by a plaintiff "as if under cross-examination."

Based on the Supreme Court's reversal of the decision of the Court of Appeals for Cuyahoga County, in the case of Oleksiw vs. Weidener, this decision means that a physician-defendant may be called by the plaintiff for cross-examination and may be compelled to give expert testimony under cross-examination.

The original case involved examination of two defendant-physicians during which questions were asked requiring expert testimony. Objections were made to such questions and sustained by the trial court. The trial court ruled that the plaintiff could not ask the defendants any questions calling for expert testimony. Plaintiff did not have any expert witnesses to testify on his behalf. The trial court granted the defendant's motion for a directed verdict on the issue of malpractice, holding that the medical problem was so involved that without expert testimony a jury could not reach a reasonable conclusion on the issue. Upon appeal to the Court of Appeals for Cuyahoga County the judgment was affirmed. The matter then was appealed to the Ohio Supreme Court.

The Supreme Court reversed the Appeals Court and held that a plaintiff in a malpractice case may compel a physician-defendant to give expert testimony on cross-examination. The decision was written by Justice Matthias and was concurred in by Chief Justice Taft and Justices Zimmerman, Herbert and Schneider. Justices C. William O'Neill and Paul W. Brown dissented.

## Ohio Institutions Benefit from Drug Foundation Grants

Smith Kline & French Foundation, sponsored by the prescription drug firm, Smith Kline & French Laboratories, issued grants to educational institutions, hospitals, etc., totaling \$861,435 for last year. Since its establishment in 1952, the foundation has disbursed a total of \$7,097,644.00.

The University of Toledo, College of Pharmacy received a grant for equipment.

In a policy of matching contributions of the firm's employees to educational institutions, the foundation made contributions to the following Ohio institutions: Antioch College, Yellow Springs; Central State College, Wilberforce; Denison University, Granville; Kenyon College, Gambier; Ohio State University, Columbus; Ohio Wesleyan University, Delaware; and Wittenberg College, Springfield.

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**pH**—values are read numerically in the essential range of pH 5 to pH 9.

**Protein**—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

**Glucose**—provides a "Yes-or-No" answer for urine "sugar spill."

**Ketones**—detects ketone bodies in urine—both acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

**Occult Blood**—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

### Now a Clear Reagent Strip of Firm Construction

...facilitates handling during testing-procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle).



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AMES





## "All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



## Many More Persons Covered Now By Insurance for Surgery

Surgical benefits paid out in 1964 by insurance companies totaled over \$771 million, the Health Insurance Institute reported.

That figure, the Institute said, is 11 per cent above 1963's \$695 million and represents a record high for this insurance.

These insurance company benefit payments were paid under surgical expense coverages, and under surgical provisions of major medical expense policies.

The Institute noted that total health insurance benefits by insurance companies last year amounted to nearly \$4.7 billion. In addition to surgical coverage, benefits were provided under hospital, regular medical, major medical, and disability income insurance programs.

Surgical benefits under a basic hospital-surgical policy are paid according to a listed scale of procedures. Schedule maximums range from \$250 to \$600, depending on the policy. Under major medical expense policies, the benefits are determined by the customary and usual fees charged for specific operations.

At the end of 1963, nearly 85 million persons had surgical expense protection through insurance company group or individual and family policies, the Institute said.

Insuring organizations such as Blue Cross and Blue Shield protected another 52.5 million, and 8.6 million persons were covered by other health care programs.

The net total protected for surgical expenses in 1963: 134.9 million persons.

The estimated surgical coverage figure for 1964 is 139 million persons, the Institute said.

Ten years earlier — in 1954 — the over-all surgical coverage total came to 86 million persons, or 53 million less than is estimated for 1964.

Here are some representative coverage totals for the intervening years: 1955 saw 91.9 million persons protected by a surgical program; 1957 — 108.9 million; 1959 — 116.9 million; and 1961 — 126.9 million.

### Ethics and Professionalism, Subject of AMA Congress

The American Medical Association will sponsor a National Congress on Medical Ethics and Professionalism at the Drake Hotel in Chicago, October 2-3.

The conference, first-such meeting sponsored by AMA, will provide an opportunity for members of the profession to exchange ideas on ways to emphasize the concern of all physicians with the high standards of conduct traditionally associated with medicine.

**Indications:** Many types of edema involving retention of salt and water.

**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.

**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

**Average Dosage:** One tablet (100 mg.) daily with breakfast. **Availability:** Tablets of 100 mg. in bottles of 100 and 1000.

For full details, see the complete prescribing information.



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**The long-acting  
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**Side effects and precautions:** The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

## OSU Surgeon Is Honored with Regents' Professorship

Dr. Robert M. Zollinger, professor and chairman of the Department of Surgery at Ohio State University, was honored with one of the first three Regents' Professorships announced by the Board of Regents in July.

In announcing the appointments, Dr. John D. Millett, chancellor of the Ohio Board of Regents, said: "The Board of Regents is delighted to be able under legislation of the General Assembly as approved by Governor Rhodes to establish Regents' Professorships in recognition of national preeminence already achieved by members of state university faculties."

Dr. Zollinger has won international acclaim as a general surgeon and teacher of surgery. He has been a member of the Ohio State faculty since 1946 and chairman of the Department of Surgery since 1947.

He was president of the American College of Surgeons in 1961-1962, and in 1963 was elected president of the Society of Surgery for the Alimentary Tract. He also has been president of the Society of University Surgeons, the Central State Surgical Association and the Interstate Postgraduate Medical Association of North America. He has been editor-in-chief of the *American Journal of Surgery* since 1958.

His most recent honors came earlier this year when he was inducted as an honorary fellow of the Royal College of Surgeons of England, and received the honorary doctorate from the University of Lyon, France.

Regents' Professorship appointments are for at least two years, the university receiving \$25,000 per year for support of each professorship.

## Mail-order Treatment of Epilepsy Denounced

The Epilepsy Foundation has issued a warning that certain drug companies are sending phenobarbital through the mail on the basis of a simple signed statement that recipient is suffering from epilepsy.

The Foundation study revealed that the operation conducted by two companies appears to be permitted by present Federal and state laws. Advertisements placed in pulp magazines offer "free information" about treatment of epilepsy. On the basis of a statement signed by the patient, a company "medical director" signs the necessary prescription, according to the Foundation's findings.

The Foundation further points out that none of the well-known ethical drug manufacturers are involved in the practice.

Dr. Max T. Schnitker, Toledo, discussed mental retardation research before a meeting of the local Rotary Club.

# Health Officers of Cincinnati, Ohio And the Problems of Their Day

KENNETH I. E. MACLEOD, M.D., M.P.H.\*

## PART IV

(Continued from August Issue)

### Dr. C. W. Rowland: 1883-1885

**D**R. ROWLAND's concern with his Board of Health's status is realized by the following statement in his annual report dated January 1, 1884:

The year 1883 furnishes a singular chapter in its history. On the 19th day of April, the General Assembly passed an act abolishing the Board of Health, and providing for the appointment of a Health Commissioner by the Superior Court of the city. That court declined to act, and consequently there was no Board of Health, until the 26th day of July, when the City Council passed an ordinance creating a Board of Health, and your Honors were chosen . . . During the hiatus, the former Health Officer (Dr. Bramble) and some assistants ran the office. The present Health Officer was elected on the first day of August, but not until the middle of last month were his assistants all chosen and all departments fully at work . . . There existed a strong prejudice against the whole department . . .

Through this revealing passage we gain considerable insight that a strong Board of Health was not always appreciated, and it explains how the "spoils" system had its deleterious effect also on its stability, for the health officers and staffs kept changing in too rapid succession. Dr. Rowland had a staff which totalled up to 44 individuals, most of them being "sanitary police" and district physicians.

Dr. Rowland was concerned with such matters as the "proposed cremation of human bodies within the city," which according to the advice of the city solicitor was not "illegal," "no legislative authority being necessary in order to cremate . . ."

### Dr. Byron Stanton: 1886-1889

In 1886, we find ourselves again with a new health officer, Dr. B. Stanton, and a new Board — no longer a Board of Health, but renamed as the Board of Public Affairs.

In Dr. Stanton's annual report — the twentieth of the Department — he notes this event, and that "the powers previously held by the Board of Health were transferred to your Board, on May 17, 1886 . . ." He noted as one of his principal concerns the problem of poor reporting of births, marriages, and contagious diseases, which "are lamentably defective. Especially is there remissness on the part of physi-

cians . . ." (And this is a problem which has not been resolved these many years later, for only one case in ten of infectious syphilis is reported according to our recent survey in 1963. K.I.E.M.)

Dr. Stanton had also his many concerns; the summer of 1887 was noteworthy, for example, "for its high temperature and prolonged drought . . . and during the month of July there were registered 122 deaths from sunstroke, and 28 during August." In his report for 1888, he noted that the city's population had increased to 325,000. The death rate was 18.44 per 1,000

the most marked decline being in the class of zymotic diseases . . . Typhoid fever is the disease in which there was the most marked decline . . . [but] consumption caused 746 deaths . . . [and] there were 1466 deaths in infants under 1 year of age. Forty-one per cent of all the deaths were in children under ten years of age . . .

(Surely a deplorable wastage of child life as compared to the present day. K.I.E.M.)

In both his 1887 and 1888 reports, Dr. Stanton noted that the chief sanitary needs of the city were:

1. Improvement of the water-supply.
2. Extension of the sewerage system.
3. Compulsory connection with sewers when built, and abandonment of privy vaults.

### Dr. J. W. Prendergast: 1890-1897

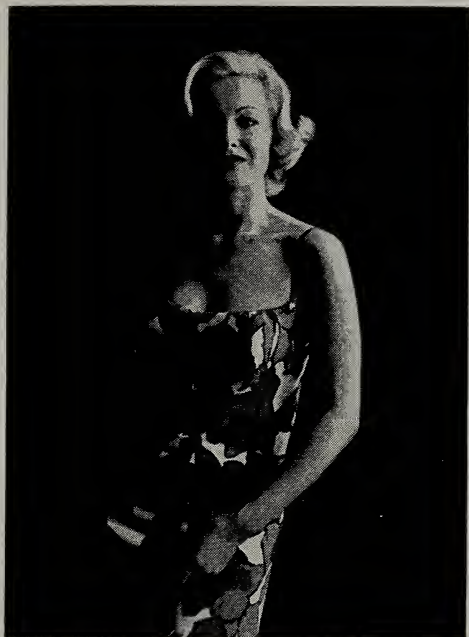
In 1890 and 1891, we find a new health officer, Dr. J. W. Prendergast, reporting to the Boards of Public Affairs and Public Improvements. In the twenty-fourth annual report of the Department, issued as of the date, January 1, 1891, he noted that the Department of Health was organized in nine bureaus:

1. Bureau of Vital Statistics.
2. Bureau of Sanitary Inspection.
3. Bureau of Markets.
4. Bureau of Meat and Livestock Inspection.
5. Bureau of Dairy and Milk Inspection.
6. Bureau of Medical Relief (the district physicians).
7. Bureau of Infectious and Contagious Diseases.
8. Bureau of Chemical and Microscopical Examinations.
9. Bureau of Law.

(Continued on Page 800)

\*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.  
Submitted October 4, 1964.





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not all your patients  
are overweight**



**but  
for those who are...**

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Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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The duties of these bureaus are given in detail. Clearly by this last decade of the 19th century all the elements of the modern health department are present, except that legal questions are now adjudicated and advised upon by the City Solicitor's Office.

Dr. Prendergast had many interests. He noted in connection with smallpox that

while we are amply and well provided for with the Branch Hospital . . . it is unfortunate that we do not have a similar institution, within the city limits for the isolation and the proper treatment of diphtheria and scarlet fever patients . . . If the kind ladies of our city . . . will give this particular field some attention, we feel confident they will find here opportunities for work that would be of a vast service to humanity . . .

On school hygiene, he stated:

The question of school hygiene is one which comes properly within the province of this department, and it is a matter of much regret that the methods now in vogue are open to severe criticism. Data are being arranged and will soon be presented to the Board of Education calling attention of that honorable body to the serious defects of the school-houses . . .

Other matters of concern were the need of permanent pasturage for dairies, abatement of the smoke nuisance, improvement in the method of collection and disposal of refuse, prohibition of overcrowding in tenements, stringent laws concerning ventilation in schools, churches, theaters, and all public buildings, and other such matters.

The population in 1892 was 305,000, about 12,000 of this total being colored. The death rate, he noted as "very large," among the colored. His urging of a better water supply, a more comprehensive isolation hospital, public disinfecting stations "lest cholera should come as expected in the summer," and an "improved" market system, all indicate that the Board of Health's influence was not without effect.

And talking of nuisances, Dr. Prendergast's inspectors investigated no less than 24,000 complaints in 1893.

The cost of medicines for the "out-door" sick poor during those years is indicated by a table given by the Health Officer:

1880 .....	\$3,582
1885 .....	\$4,520
1890 .....	\$4,340
1893 .....	\$1,529

#### Dr. J. M. Withrow: 1898

Dr. Withrow, writing on the subject of medical school inspection, noted:

From experience elsewhere it has been shown that it has been wise for some system of inspection to be adopted with a view to preventing as far as possible this source of infection. To this end the Board of Education should appoint a corps of inspectors, who should be physicians of unquestionable ability. Each school inspector should be assigned to such schools as he could easily inspect the first hour of the morning school session each day. The teachers in the various schools, should, immediately after roll-call, inspect the pupils under their charge with a view to ascertaining their condition of health. All children who do not appear

to be perfectly well should be sent from the schoolroom to a suitable room in the building, where the physician could carefully examine them . . .

In this passage we have all the elements of the present-day school health service outlined: the role of the school physician, the role of the school teacher, and the screening of pupils. Even the need for a health room is implied. The only member of the school health team not mentioned is the nurse. But it is not going to be too long before we find that very necessary member mentioned, and mentioned often, in these annual reports.

#### Dr. W. A. R. Tenny: 1899

The department was organized into 12 separate bureaus under Dr. W. A. R. Tenny, that is in addition to the previous list (see Prendergast), he has added a Bureau of Fruit Inspection, a Bureau of Finance, and a Bureau of Disinfection.

In his annual report, Dr. Tenny noted the satisfactory drop in the death rate from 18.44 in 1883 to 13.79 in 1898. Only Louisville and St. Louis had attained as low a record among the larger cities. The population of the city was now 405,000. The principal causes of death were tuberculosis, pneumonia, heart disease, bronchitis, typhoid fever, diphtheria, dysentery, influenza, and scarlet fever. Dr. Tenny emphasized that tuberculosis and smallpox were the chief public health problems. In regard to tuberculosis he wrote:

Consider the great panic that would be produced if an epidemic of smallpox or yellow fever should cause the death of 700 persons in Cincinnati and 6,000 in New York City in one year; yet this is the annual deathrate in these cities from consumption, and the citizens and the municipal authorities have apparently become resigned to this sad condition . . . Our chief weapon against this disease therefore lies in prevention. This can best be accomplished by isolation of the cases . . .

On smallpox, he urged the enforcement of a regulation requiring the vaccination of school students.

All children who do not furnish satisfactory evidence of having been successfully vaccinated will be required to remain away from school after Monday, December 5, 1898. Provision is made by the Health Department to vaccinate all children whose parents are unable to pay for the same through the district physician . . .

The district physicians were responsible for the maintenance of health conditions within their districts — as "assistant health officers." They also had to visit and prescribe for all sick persons unable to pay for private medical advice. Dr. Tenny instituted regular monthly meetings for these physicians. He applauded the reduction in cost of medicines from \$4,000 per annum in 1880 to about \$250 as of the present time, "this decided reduction in cost" being the result of a change made in the method of supplying these medicines. Since 1893 the Board of Health had purchased them wholesale in tablet form, and supplied the district physicians directly.

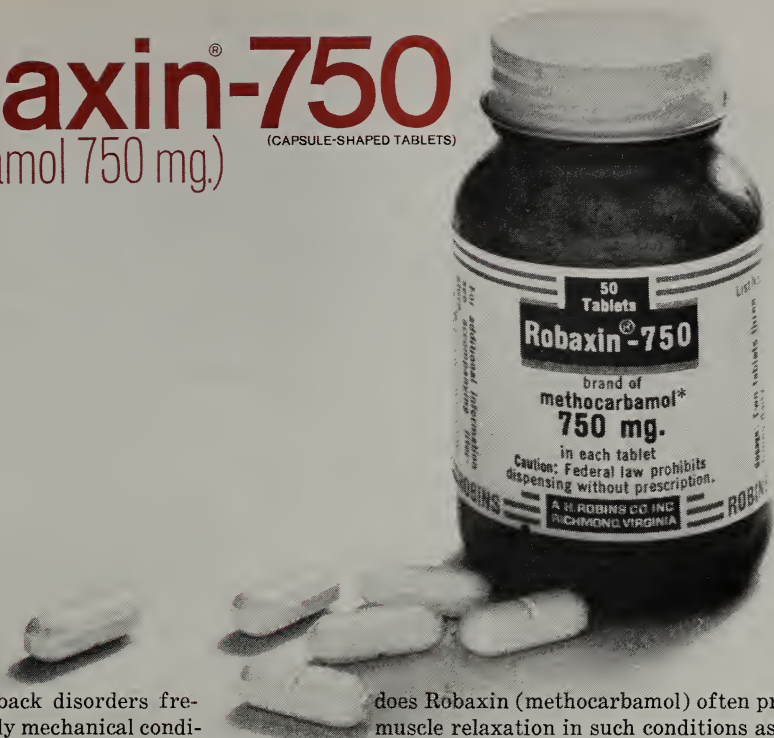
*(To Be Concluded in October Issue)*



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It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."<sup>1</sup> Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."<sup>4</sup>

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."<sup>6</sup> A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants..."<sup>6</sup>

A well-tolerated<sup>7</sup> skeletal muscle relaxant with "specificity of action,"<sup>7</sup> methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation<sup>7</sup>—a considerable advantage for the patient who must remain active and alert on his job.

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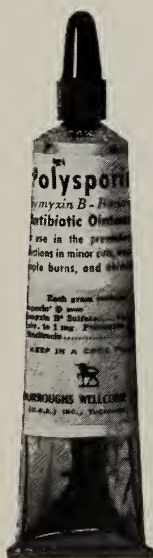
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Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
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# Scientific Section

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## Resistance to Therapy

### A Discussion of Resistance as Seen in Private Psychiatric Practice

J. M. WITTENBROOK, M.D., HAROLD R. FISHER, Ph.D., JAMES A. BARD, Ph.D.,  
and JACK M. LORENZO, Ph.D.

THE concept of resistance originated in the observations and inferences of psychoanalysis. It was conceived to account for the fact that persons who had voluntarily submitted themselves to therapy for their own sake proved to be psychologically unable to cooperate fully. Since most psychoanalysts work mainly with carefully screened and selected patients and because psychoanalysis is so individual-centered in its conception and application, the idea of resistance was defined in terms of those intrapersonal dynamics which retard or block the therapeutic process.

Without intending to change the essential meaning of this concept, we do wish to suggest that it might be expanded somewhat so as to be applied to a broader range of therapeutic challenges. In the general private practice of psychiatry and clinical psychology we see a great many problems which are not suitable for analytic psychotherapy, for many reasons. Therapy in general private practice is a broad term which includes medication, electroshock therapy (ECT), suggestion, family counseling and instruction as well as analytic psychotherapy. And we find "resistance" in all shapes and forms attendant to any and all of these procedures.

We feel that broadening the usually restricted

#### *The Authors*

- Dr. Wittenbrook, Cleveland, is a member of the Active Staffs of St. Vincent Charity, Ingleside, and Marymount Hospitals; Consultant at the following Hospitals: Doctors, Huron Road, St. Alexis, and Euclid-Glenville; Instructor, St. John's College.
- Dr. Fisher, Cleveland, Psychologist.
- Dr. Bard, Cleveland, is Associate Professor, Fenn College, Cleveland State University.
- Dr. Lorenzo, Cleveland, Psychologist.

meaning of the term may provide a conceptual basis for dealing more effectively with *all* the problems which are encountered in general practice. To this end we suggest that "resistance" may refer to any and all forces, conditions and events which retard and/or block the change and development which any therapy aims to achieve. We are concerned with such questions as, "How to persuade a family to hospitalize one of its members — or, having done so, to leave the patient in the hospital until the patient improves" . . . or, "How to convince parents to continue therapy for a child who has only temporarily stopped misbehaving." These and other similar situations serve to remind us all that we

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frequently fail to achieve the hoped-for results in our day-to-day clinical work.

In general, we wish to discuss the many "forces, conditions and events" which retard or block therapy. Let us begin by organizing and classifying them according to their *source or origins*.

First, there is resistance which arises entirely from a source outside the patient and operates outside the patient. Second, there is resistance which arises from a source outside the patient but which operates through the patient. Third, there is resistance which arises within the patient and operates through the patient. And finally, and perhaps most important to the clinician engaged in general private practice, there is a general resistance which arises from ignorance within and *around* the patient and which operates through and *around* the patient. To some extent this kind of resistance can be found in all patients for they, as members of a society which is only beginning to recognize the complexity of human behavior, are venturing into the unknown when they consult the professional about their personal problems.

#### The Resistance of "Others" Interests

Resistance which arises outside the patient and operates outside the patient can be illustrated in various ways. There is the obvious case of the child whose parents are reluctant to support the therapeutic undertaking even though the child may be emotionally available for therapeutic involvement. There are many reasons for this type of resistance and they should be recognized and understood. By support for the therapeutic undertaking we mean investing time, money, and themselves as parents. Therapy may fail for reasons of parental resistance in any of these areas.

Therapy in a private practice setting costs money, sometimes a considerable amount of money, and to most families money means other important considerations. It means pleasure. It means security. We are asking the family to give up some pleasure and some security for what may seem to them to be a questionable procedure. And in fact it is a questionable procedure, for none of us is so successful that he can guarantee the desired results. As difficult as this resistance can be, it is sometimes more easily resolved than would at first appear possible. Conferences with the parents, in which the purpose and need for therapy are explained meaningfully are frequently of great help. We should appreciate the feelings of parents or, for that matter, the feelings of husbands who are only aware that there is a continuing process going on for which they are expected to pay. Too often we overlook this important consideration and thus allow resistance to generate which will ultimately terminate the therapy.

On the other hand, the reasons for resistance may originate at deeper levels. We may be dealing with a family all of whose members are disturbed. The parents may have avoided treatment of their own

EDITOR'S NOTE: Although the authors' discussion is directed primarily at psychiatrists, the concept of resistance to therapy has applications to every field of medical practice. These applications will become evident to the reader as he peruses this excellent paper.

In addition, the authors make it clear that those of us referring patients for psychiatric care are in a position to help minimize resistance through appropriate preparation of the patient and his family.

problems because they have been able to "get by" but the child is not so fortunate. He is not "getting by." These parents may fear exposure of their personal problems and so, even though they may be willing to pay the costs of therapy for the child, they are unwilling or unable to invest of themselves in resolving the problems. Interestingly enough, in some of these cases it seems that the parents are spending money in the cause of resistance, e. g., they reassure themselves that they don't need to do anything personally because they are paying someone else to do it!

#### The Resistance of "Good" Excuses

Then there is the resistance which arises outside the patient but which operates through the patient. One common example of this is the wife who has her own inner reasons for resisting, but who uses the *fact* that her husband complains about the costs as her excuse to hide her own resistance. This is a ticklish situation because there is some reality underlying her claim and, as advocates of the reality principle, we must not too casually dismiss such claims. Here again, conferences with the parties concerned may be helpful.

Another example, which is not as common as it is interesting, is a recent case of a 16 year old boy who had to "check" with his parents in the reception room to be sure of what he was permitted to say. Although these parents had created this procedure for their own purposes, it soon became apparent that the boy had adopted it for his purposes, namely resistance. Only by conferring with the parents and resolving *their* resistance were we able to secure their cooperation in dealing with the boy's.

#### The Classical Resistance

Our third category deals with resistance which arises within the patient and operates through the patient. This is the classical type of resistance originally defined in the Psychoanalytic system. We do not need to elaborate upon this except to briefly review the various manifestations which are so common. Perhaps the most obvious of these is changing appointments at the last minute, breaking appoint-



ments, arriving late for appointments or at the wrong time. In this latter case we have found appointment cards helpful, not because they eliminate the resistance, but because they make it somewhat easier to document the reality in question.

There is the tendency of some patients to discuss everything except those matters of real importance. Some of this might be excused in the early stages of psychotherapy on the grounds of being a means of producing a relaxed atmosphere and promoting better rapport. One sign that it may be significant resistance is to be seen when the patient complains at the end of the hour that he had an important problem to discuss. When this occurs we frequently make a note of it and then raise the question at the outset of the next session. Here again we have no illusion that such a procedure eliminates the resistance, but we do find that it helps in our efforts to get the patients to see that resistance is taking place.

Some patients are amusing and entertaining during the therapeutic sessions. This is particularly likely to be the case if they discover an area of particular interest to the therapist, e. g., music, art, etc. And we must be aware that not all such conversational efforts are necessarily resistive in nature. Psychotherapy is fundamentally a matter of human relationship and must therefore allow for some generally human interchange.

One of the most clever and challenging forms of resistance is the pseudo-sophistication of some patients who are relatively well read and who possess sizeable vocabularies in the psychiatric and psychological fields. The more intelligent of these persons are not always easily diagnosed as resistant until it becomes apparent to the therapist that the conversation has gone full circle without any real progress being evident.

A final example of personal resistance to be encountered in the analytic type of therapy is the use of hostility to frighten the therapist back to safer ground. The patient may question the training or qualifications of the therapist. He may seize upon the inevitable errors in billing, the faulty elevator in the building or the "undesirable" location of the therapist's office as a point to engage the therapist in debate rather than explore his own difficulties.

### **The Resistance as Social Ignorance And Inertia**

As for the fourth category of resistance which we feel arises in and reflects the ignorance of society in general and the ignorance of the patient in particular, we have one suggestion to offer — education! It must be apparent to all those who work in the fields of mental health that ignorance is the dragon to be slain. We in the general private practice of psychiatry and clinical psychology see the final results of ignorance every day — not only the results in human suffering, but also the results in resistance which prolong and perpetuate the suffering. In the space

allotted here, we cannot begin to cover this subject adequately. However, we do feel that a few of the more crucial manifestations should be mentioned.

We are all members of the Community and so we must all bear the responsibility of whatever may be the shortcomings of the Community. Perhaps we, the clinicians, should bear more of the responsibility, for we at least claim to be enlightened. Our communities have not yet come to fully realize that delinquent children are misbehaving for reasons of emotional need. And so, when the Community sends to our offices some delinquent, juvenile or adult, it does so with only limited willingness to make the changes which are really necessary to resolve the problems. Like so many resistant parents, the Community does not want to pay!

Among the professions, education, law, and medicine, there is a great deal of resistance to be found. Very frequently the resistance is excused on the grounds that psychology and psychiatry are nothing but sophisticated forms of witchcraft. And sometimes, to those of us who work with troubled people, it seems there may be some grounds for such a charge. We do succeed at times and we fail at other times without knowing exactly why. However, there can be no doubt that some of our failures are due in part to the general lack of understanding which prevails in the Community at large. This is ignorance which results in resistance to changing those conditions in our society which foster and promote human maladjustment. And this same resistance makes it virtually impossible to correct many of those maladjustments which have already developed.

To be more specific, we advocate programs of education at all levels of society so that childhood disturbances may be detected more quickly; so that marital maladjustment may be viewed as a human problem to be solved rather than a trap to be escaped from through divorce; that potential criminals who are now engaged in minor delinquencies may be helped to find a more satisfying and constructive way of life. These are ideals, to be sure. But every human achievement was an ideal at some time in its development.

On the level of the individual patient or family, the job of education is frequently the most important aspect of the therapeutic undertaking for it may determine whether any therapeutic contact is made and continued. Many families are so completely naïve that it is incomprehensible to them that something as vague as "feelings of rejection" might be related to low grades in school performance or a suit for divorce. If there is to be any therapeutic resolution of these problems there must first be accomplished a meaningful job of education. Hopefully this education will begin no later than the point at which the referral is originally made. This means that physicians, lawyers, educators and others have an extremely important part to play. Those of us

in general clinical practice of mental hygiene urgently need this help, and will be most grateful to get it.

\* \* \*

#### DISCUSSION

By L. E. WHITMIRE, M. D.\*

In any discussion regarding the dynamic processes of psychiatry one must always consider the possibility that this has already been written by the master, Dr. Freud.<sup>1</sup>

It is true that as Dr. Wittenbrook, in his paper, has pointed out there is a scarcity of material published on the subject of resistance seen in private practice. However Dr. Freud did write in 1925, of the resistance to psychoanalysis and stated that a particularly bad reception was accorded psychoanalysis when he began to develop this technique some 30 years before utilizing the discoveries of Joseph Breuer. He referred to the novelty of analysis as a significant aspect of resistance. He also took into account the philosophic difference of the scientific attitude as opposed to a theistic faith in the supernatural, and of course we are all aware that the initial resistance to sexuality in childhood created a strong resistance which retarded the acceptance of psychoanalysis, not only by the lay and religious groups but also in the medical profession itself. This has not been overcome even today as I will refer to later.

Dr. Wittenbrook has attempted to describe the multiple kinds of resistances which are currently in the private practice of psychiatry. He suggests that this is an area where greater study and understanding is indicated and hopes to stimulate interest in this area. It is my feeling that the various types of resistances that he has described could each provide many hours of symposia and workshops on each type of resistance.

He begins his paper with a description of some external resistances including the consumption of time and the cost for the therapist. He also refers to the resistance of the child who sees therapy as an additional method of parental punishment and he also notes the frequent lack of preparation of the child for therapy by the parents.

\*Dr. Whitmire, Toledo, is Staff Psychiatrist at St. Charles Hospital, Toledo Hospital, and Riverside Hospital, Toledo.

He goes on to discuss also the intrinsic resistances which are inherent in the giving up of neurotic mechanisms. The feelings of the patient when a conference with another member of the family is necessary, which in turn may also provide some external resistance from the "paying" member of the family. He describes the methods utilized by the patient regarding resistance to appointments. This seems to be a favorite technique with the outpatient who is "too busy" to get to the office at an available time. The discussion of remote events is of course a frequent resistance and the failure of the therapist to "cure" the patient is one of the more threatening devices that they are able to utilize.

Dr. Wittenbrook has not been able to elaborate point by point either the complete classification of resistance nor in this amount of time could he possibly have given a very complete discussion of the methods of dealing with this but this is of course, as you all know, a necessity in the psychotherapeutic processes. I am sure that you, as well as I, have had difficulty with all of these previously described forms of resistance.

There is one type of resistance which Dr. Wittenbrook does not cover and which I feel is rather a significant point. Dr. Freud mentioned this in his article previously referred to, and in one of the recent reports of the Group for the Advancement of Psychiatry entitled "Medical Practice and Psychiatry,"<sup>2</sup> it is pointed out that resistance to psychiatry does originate with physicians, as well as with patients. In this article a significant point is made regarding the relationship of the psychiatrist to the general physician and it is noted that these nonpsychiatric physicians tend to fall back upon the excuse that "I am no psychiatrist" and the psychiatrist tends to blame the generalist for being psychiatrically naïve.

I do hope, along with Dr. Wittenbrook, that this has promoted some interest and further observations in this specific area of resistance.

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**THE HOSTILE PATIENT.**—The physician handles irrational hostility of the patient best by (1) recognizing it as a symptom of underlying psychiatric problem, (2) giving consideration to the contributing reality factors, (3) allowing the patient to ventilate and abreact if necessary, (4) accepting the patient's hostile feelings without allowing them to distort his own feelings, (5) remaining non-judgmental and noncondemning, and (6) avoiding dynamic interpretation of hostility. When one properly manages the hostile patient, he is rendering a great service to the patient, himself and the profession.—Harry K. Davis, M.D., Galveston, Texas: *Southern Medical Journal*, 57:563-566, May 1964.



# College Psychiatry, a Challenge

EDWARD KEZUR, M. D.

WITH the burgeoning enrollment of the college population, it behooves us to pay more attention to meeting the particular mental health needs of this group. According to The Department of Commerce college enrollment projection, there were 3.6 million students enrolled in college in 1960. There will be 5.8 million by 1970 and 7.8 million by 1980.<sup>1</sup> The college setting offers a unique opportunity for a psychiatrist to work amongst a heterogeneous group of people, to demonstrate his usefulness, and to implement a therapeutic and preventive mental health program.

## History

Although it is difficult to determine, there is suggestive evidence of the first psychiatric service in an American college being started at Princeton by Dr. Stewart Patton in 1910.<sup>2</sup> By 1930 there were probably no more than 15 colleges with active psychiatric services. Clements Fry in 1926 was one of the early pioneers in college mental hygiene. He later went on to make a full-time career of it and wrote in 1942, "Although there are now mental hygiene services in many college communities, a university psychiatrist is widely considered a luxury, and in many places not sought after."<sup>3</sup> Following World War II, the general upsurge in psychiatry brought a trickle of more psychiatrists into college health work.

Despite the fact that there are now 4.5 million college students, there are only about 50 psychiatrists interested in mental health of college students. It may be that the average psychiatrist does not feel as much at home practicing in the college setting as he does in the hospital or private office. Furthermore, the limited pay afforded psychiatrists by colleges tends to discourage their pursuing this type of work.

## Role of College Psychiatrist

The role of the college psychiatrist differs, to some extent, from that of the private practicing psychiatrist, the psychiatrist in a mental hospital, or the community mental health clinic and medical school faculty. The college psychiatrist is cast in the role of representing the institution as well as his patient. He is expected to provide diagnostic consultation and brief psychotherapy, and to consult with college administration concerning general college problems like

## The Author

● Dr. Kezur, Hamilton, is Director of Psychiatric Unit, Hughes Memorial Hospital, Hamilton; Instructor in Psychiatry, University of Cincinnati College of Medicine; Psychiatrist, Student Health Service, Miami University, Oxford; and Counseling Service, Western College for Women, Oxford, Ohio.

dropouts, poor risk students, cheating, or stealing. He acts as an adviser to the director of the student health or admissions committee in regard to the admission of students as well as their separation. He has the challenge of applying preventive psychiatry in a small community. He not only has the opportunity to apply his diagnostic skills with ill students, but also can see relatively healthy students reacting to mild situational reactions.

Furthermore, some of the individual needs of the psychiatrist can be met by the college. Status is accorded him via a title or faculty appointment. For the academician, library facilities are available. There are broad cultural exposures on every college campus in the areas of hearing lectures, attending concerts, art exhibits, and viewing athletic events.

One of the most outstanding and indefatigable workers in the field of college mental health is Dana Farnsworth who is Director of the Student Health Service at Harvard University, which is a unique position for a psychiatrist. Dr. Farnsworth concludes the goals of college and university services are gradually becoming clearer. He cites the following:

1. Treating sick students or those who may become so if their conflicts are not mitigated.
2. Changing attitudes of students, faculty, and employees toward emotional problems from aversion, fear, or denial to understanding, tolerance, and cooperation in their management.
3. Improving relations between students and college staff to the end that learning may be enhanced.
4. Freeing the intellectual capacity of students to do creative and satisfying work.<sup>4</sup>

## Description of Work Setting

The material for this paper is drawn from my experiences in working at Miami University, a state institution, and Western College for Women, a pri-

<sup>1</sup> Presented at the winter meeting of the Ohio Psychiatric Association, January 20, 1965.

vate women's college. The former has a coeducational student body in residence of approximately 9,000; the latter, a student body of 500 women. The nature of the work is the same in each institution. The differences between them might be likened to living in a small town versus living in a large city. Communications are more personalized in the smaller college, where there is more frequent contact between the psychiatrist, the Dean of Students, the social worker counselor, and faculty.

At Miami, the psychiatrist works in the setting of the Student Health Service and is directly responsible to the Director of the Health Service. Appointments are made through the Health Service, coming from a variety of sources, but mostly from the physicians in the Health Service and from counselors in the Counseling Service. Through the years, meetings have been held with the Dean's staff, heads of women's residences, men's residences, hospital nurses, psychology classes, and Student Personnel Services classes. There is a regular monthly meeting with representative key student services, which constitute the Mental Health Committee. The function of this group is to consider and suggest measures which may contribute to the overall mental health of our college community. It is also concerned with the sharing of information about troubled students who may be seeking help from more than one service. Another function of this committee is to provide a forum for arriving at a group decision in regard to a particular problem student. The Student Affairs Executive Committee meets at a supper meeting once a month to discuss broader problems pertaining to our University, such as sexual behavior in colleges, the rights of students to select campus speakers, student aid, institutional research, and freedom of speech in colleges. The psychiatrist is a welcome participant in these meetings, which not only provide intellectual stimulation but also occasions to become better acquainted with people of other disciplines.

At Western College, the psychiatrist works in the setting of the Counseling Service, which is conducted by a part-time psychiatric social worker. All appointments are made through her. She also arranges for conferences with the Deans, Heads of Residence, the Director of Admissions, the College Pastor, faculty, and Health Service personnel. The major treatment at Western is rendered by the social worker in the form of short term counseling and relationship treatment, which involves some interpretation of student's behavior, support, and bolstering of the student's ego strengths. The psychiatrist, in providing consultation for the Counselor, Deans, or other faculty, interviews students screened first by the Counselor. He attempts to establish a diagnosis and to provide suggestions for ongoing counseling if necessary. Occasionally, there are direct referrals to the psychiatrist from the Dean or College Physician. The availability of a psychiatrist to the college on a

regular visiting basis provides a sense of security to the college.

### Diagnosis in College Students

One sees the whole range of human behavior in the college setting, varying from the normal to the pathologic. Many of the problems seen are those of normal young people, often made more intense by the turbulence of youth. As Ingham says,

The Students are young striving adults who are striving in that they are trying to get ahead and to be more this year than last, and more next year than this year. A natural development is the emancipation from parental authority. They are exposed to new ideas and values and are confronted with making independent decisions such as a choice of career, religion, politics, and the establishment of sex patterns.<sup>5</sup>

Since the personality and character development of the college student is changing, psychiatric diagnoses are not always distinct. Perhaps this is because the ego is still in the process of reforming. The young person has still not attained a stable identity. Robert Nixon at Vassar College writes about students who fail to fit a diagnostic categorization. In a group of 1000 students seen in the psychiatric service at Vassar, Nixon concludes that 20 per cent were diagnosable, another 20 per cent are an unknown quantity, and the remaining 60 per cent are students

who do not have presenting complaints; instead, they have presenting questions; they seek answers rather than solutions, knowledge rather than relief from symptoms. They appear to perceive the college psychiatrist more as a teacher than as a therapist.<sup>6</sup>

It is pertinent to make some comment about the identity crisis concept which is viewed as a normal phase of adolescence, and necessary to resolve in the attainment of health maturation, since this is a frequently encountered problem. Erikson, who gave us the term, "identity crisis," writes:

The growing youths, faced with this physiological revolution within them, are now primarily concerned with what they appear to be in the eyes of others as compared with what they feel they are, and with question how to connect the roles and skills cultivated earlier with the occupational prototypes of the day. In their search for a new sense of continuity and sameness, adolescents have to refight many of the battles of earlier years, even though to do so, they must artificially appoint perfectly well-meaning people to play the roles of the enemies.<sup>7</sup>

When this sense of identity is attained, Erikson goes on to describe it as

a feeling of being at home in one's body; a sense of knowing where one is going; an inner assurance of anticipated recognition from those who count. We are most aware of our identity when we have just gained it, and we are somewhat surprised to make its acquaintance.<sup>8</sup>

The following is an example of a student experiencing a mild identity crisis. She was an attractive, casually dressed sophomore who came to our Counseling Service experiencing ambivalence about whether or not to remain in college. She had flunked a test. She had also come in late from a date and had been



campused. She expressed guilt over her repeated arguments with her mother at home.

Upon interview the following week, she indicated the problem had resolved itself to some extent. Although she didn't know what was troubling her, she felt much better. She had been considering the purpose of her being in college and what she would do in the future. She herself generalized that she was in a slump, similar to those described in letters by friends at other colleges.

In her freshman year she was enthused about college, worked hard and dated. The future did not even seem imminent. This year she was preoccupied with future goals. In the course of questioning her relationship with peers, and her religious values, she became depressed. She thought of withdrawing from college, but realized that it wouldn't solve her dilemma. She concluded that she was determined to remain at college and not goof off. The depression and hopelessness left her. She rejected any need for further interviews, stating she didn't want to rely upon a crutch.

Since many college students are seeing a psychiatrist for the first time when they come to the Mental Health Service, I attempt to make it a positive and educational visit. For some, it may be a single visit. I spend half a day each week at Miami and at Western, and it is not feasible to see a student several times, nor is it always necessary. For many, an opportunity to ventilate and ask questions in a permissive non-judgmental atmosphere is sufficient. Students demonstrate little resistance in the interview and seem to get on with the job at hand in the headlong dash to the core of their dilemma. They seek interpretations and sometimes demand them.

### Withdrawal and Readmission

In regard to more disturbed students, the evaluative goal is to ascertain whether or not they can remain on in college with a minimum of help and function adequately academically and socially. Since the students are in residence at the above colleges and often share a room with one or two students, it is important that they refrain from arousing conflict in their roommates. Students who are more disturbed may be seen in brief psychotherapy a few times during the semester. If it is apparent that they will require more treatment, efforts are made to prepare them for referral to a psychiatrist or a mental health clinic in the vicinity of their home. Sometimes the student visits a psychiatrist at home during vacations, and may be able to plan psychotherapy on an elective basis. In rarer instances, when students are psychotic and are suffering from severe character disorders, they are sent home for treatment and the school year deferred.

The readmission of students who have been withdrawn from college because of emotional illness sometimes presents a conflict between the college and the psychiatrist or physician who endorses the stu-

dents' return. From the vantage point of the practicing community psychiatrist, sending the students back to college is often viewed as a therapeutic maneuver. It will be good for them. They will be removed from the stressful home environment. However, the college environment may be just as stressful. In view of the increasing number of college students, colleges can ill afford to readmit poor risk students. In general, the above mentioned colleges are receptive to readmitting a student withdrawn for psychiatric reasons, when there is evidence of improvement under ample treatment and also when there is evidence that the student has engaged in some constructive, successful activity for a semester or more since the withdrawal. We are more receptive to readmission of the student if the endorsing psychiatrist writes a frank, comprehensive summary of treatment and if the family displays a cooperative attitude toward the college.

James, a 19 year old sensitive, robust, junior art major was referred because of self-inflicted wrist lacerations the night prior. He was accompanied by his father who drove hundreds of miles upon learning of his son's suicidal attempt.

James had been preoccupied about what he had wished to become and concluded it would be easier to quit. On the night of the suicidal attempt he saw a girl, upon whom he had a crush, with another boy. He was tired of repeated depressions, was self-depreciatory, feared he was losing interest in his art major, and surmised he had disappointed his parents by failing to excel.

He was the oldest of two. He was always youngest in his class in high school and viewed by peers as a skinny runt, and was the brunt of teasing. Although his parents were described as compatible, father was careful and systematic, whereas mother was impulsive.

He had thought of suicide many times in the past and made a feeble attempt the year prior. He expressed shame over the recent suicidal attempt and ambivalence about remaining in school. He concluded the suicidal attempt was a bid for attention and discovered that his parents did not expect him to excel. He felt they really cared about him and that he was welcome at home. He plans to pursue his education as an art major with the ultimate goal of teaching.

This is a rather typical case of an acute crisis in a student with some identity problems, which culminated in depression and a hysterical suicidal attempt. Intervention by hospital personnel and his parents effected some resolution of his dilemma. It was felt he had sufficient strength to remain in school and would be followed in some brief psychotherapy the remainder of the year.

Such students present a challenge in being reintegrated in a college setting. However, if their emotional illness has subsided and they show academic

promise with evidence of sincere motivation for continuing their education, we usually reaccept them. Some of these students do eventually become more stabilized if they begin to attain some success academically or socially or effect a meaningful relationship with one person. If they become unduly disturbed again, there is no other recourse than to recommend withdrawal and to ask the parents to seek psychotherapy for their son or daughter at home. Unfortunately, because of the paucity of psychotherapists, it is very frustrating to patients and families to have psychotherapy recommended and then be unable to procure it.

At the end of each academic year an annual report of my activities is sent to the President of the University. In a recent report, I commented on the problem of attrition of students which was becoming of increasing concern to educators. About half the students attending American colleges fail to advance to the point of getting an undergraduate degree. The percentage of students graduating was lowest in the state universities and highest in the most selective colleges as Harvard, where 88 per cent of the enrollees go on to get a degree. It was felt that the American college is organized primarily as a training center for a career rather than as a basic intellectual center. Consequently, many students direct a major portion of their energy to the use of manipulative techniques to attain a particular goal. When our society was more rural, our youth had the opportunity to work out problems in other fashions with a relative absence of guilt. In the present day, they have to resort to manipulation of environment, parents, and college procedure with ensuing guilt and failure.

Dr. John Millett, former President of Miami University, now Chancellor of the Board of Regents of the State of Ohio, replied to the above:

I agree that we have some very real problems among our students insofar as their attitudes toward higher education are concerned. It is not easy to eliminate this problem from a state university campus, and I am not certain that we ought to try. The highly selective admission programs of most Eastern colleges probably result in bringing into their student bodies the most highly motivated students in American society. The role of a state university is different. It must provide educational opportunities for the average student, average in mental ability and often average or less in motivation. Frequently we get the student who is in college because of family pressure or some external factor. The best we can do as I see it is to provide an opportunity for this student to become interested in higher education. This is a task which demands the best efforts of everyone in the university.<sup>9</sup>

As we all know, the great advances in medicine have been made through the preventive methods such as public health measures and immunization programs. In our own field of psychiatry, we are just now struggling to develop a practical preventive approach in regard to mental illness. This is our challenge. Heretofore, we have been preoccupied with psychopathology, diagnosis, and treatment. However, this is really not enough, for there may never

be a sufficient number of psychiatrists to treat those already ill. If psychiatric insights can be instrumental in the prevention of mental illness, shouldn't they be applied to a segment of our population, the college students, who are still in their formative years? Not only can the psychiatrist contribute to enhancing the students' health, but also by liberating the students so that they are freer to learn and partake of the American educational institution upon which our society places so much value today. Work with college students offers a unique opportunity to divert young people from illness to health. They are the cream of our national intellect and will ultimately become our leaders and professional people.

As Dana Farnsworth so aptly says,

Most illness is in the foreground and regaining health the goal; whereas the educational psychiatrist spends his time in an environment in which health is assumed and deviations from it are to be recognized and dealt with or prevented if possible. Psychiatrists working in colleges or universities have an advantage over psychiatrists in private practice or the mental hospital.<sup>4</sup>

The college psychiatrist sees practically the whole range of human behavior in a period of life when the personality structure of young people is in a state of flux, with illness relatively uncrystallized. He sees young people who are often only temporarily handicapped by emotional problems which are as yet not clearly defined as mental illness. Hence, the availability of a psychiatrist in the college setting may help meet the preventive challenge.

### Summary

In summary, attention is called to the rapidly increasing college population. There are relatively few psychiatrists working in colleges and universities. A history of the development of college psychiatry is given. A college psychiatrist's work is described at a moderate sized state university and at a small college for women. The "identity crisis" is described as well as differences in diagnosis from ordinary psychiatric practice. Problems in the withdrawal and readmission of students are discussed. There is communication between the college administration and the psychiatrist. Attention is focused upon the opportunity for the application of preventive psychiatry with a significant group, namely the college student. On the whole, college psychiatry is not only a challenging experience, but a rewarding one, too.

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# Management of Corrosive Esophagitis In Children

ANDREW W. MIGLETS, JR., M. D.

IN SPITE OF efforts to educate the public, the accidental ingestion of caustic materials remains a problem. Such poisoning is seen most frequently in small children.<sup>1</sup> At the Children's Hospital in Columbus, Ohio, an average of five children with the history of ingestion of a caustic material are evaluated each month. Damage to the esophagus can be present in these children with minimal initial symptoms. If treatment is delayed, stenosis develops that later requires frequent dilatations or even extensive surgical correction.<sup>1-3</sup> Therefore the early diagnosis and correct treatment of these lesions is imperative.

## The Nature of Esophageal Burns

Corrosive agents commonly ingested are sodium hydroxide (Drano®, oven cleaners, and lye), ammonia, bleach, potassium permanganate and Clinitest® tablets. The majority of caustic agents ingested are alkalies, which are more likely to develop esophageal scarring than are the burns caused by acids or halogens. This is because an alkali produces liquifaction necrosis of the esophageal mucosa, which may penetrate to the muscularis or even beyond. Such deep destruction of tissue leads to scarring with resultant esophageal stenosis. Acids, on the other hand, produce a coagulation of the superficial layers, preventing damage to the deeper structures with less likelihood of stenosis. Halogens may cause superficial burns that are rarely complicated by stricture formation.<sup>4-6</sup> The degree of initial esophageal burn varies with the volume of the ingestant, its concentration, and its physical state (liquid vs. crystalline). Also important is the fact of regurgitation, since vomiting re-introduces the caustic into the esophagus with the likelihood of additional damage.

Acute esophageal burns are classified as first, second, and third degree, depending on the depth of tissue necrosis. A first degree burn involves only the mucosa and submucosa. It appears through the esophagoscope as an area of hyperemia with some superficial desquamation. Such a lesion is rarely associated with stricture formation. Second degree burns involve the muscular layers of the esophagus, and appear as blisters, ulcers, or areas with a patchy

## The Author

• Dr. Miglets, Columbus, is a Resident in Otolaryngology, The Ohio State University Hospitals.

membranous exudate. Third degree burns penetrate all layers of the esophagus and may involve the periesophageal structures as well. Initially they appear as areas with deep loss of the epithelium, later there are granulations.<sup>6, 8, 10, 11</sup> Patients with third degree burns are likely to develop periesophagitis and mediastinitis with significantly higher morbidity and mortality.

Burns are usually found at the three levels of the esophagus where an obstruction to flow takes place; the cricopharyngeus, the crossing of the left mainstem bronchus, and at the cardia.<sup>6</sup> Burns at the level of the cricopharyngeus are the most common, while those at the cardia are usually the most severe since they are frequently associated with reflux.<sup>8</sup> Circumferential burns are more likely to produce a stenosis than linear burns.

## Evaluation of Patients with Suspected Burns

The initial treatment of caustic ingestion varies depending upon how soon the child is seen and upon the apparent severity of the burn. Neutralization of the offending agent, advocated by some,<sup>8, 12</sup> is probably of slight value once the caustic agent has passed through the esophagus into the stomach, since the stomach is relatively resistant to corrosive substances. Furthermore, the delayed use of antidotes or neutralizing agents may induce vomiting, which is to be avoided since this re-introduces the caustic into the esophagus with the possibility of further damage. Water given immediately following the ingestion of a solid caustic flushes the agent through the esophagus, decreasing its contact with the mucosa. Water is less likely to cause vomiting than vinegar, egg white, milk, or some of the other commonly used antidotes.

The effectiveness of water in clearing the esophagus was brought out by Tomsovic,<sup>21</sup> who mentions a confused patient that took highly caustic Clinitest

From the Department of Otolaryngology, University Hospital, Columbus, Ohio. Submitted February 1, 1965.

Tablets orally for several weeks without suffering esophageal damage. However, he washed down each tablet with a large glass of water. Localized esophagitis has been reported following the ingestion of sodium Amytal®. Chloromycetin®, Benadryl®, and aspirin when they were not followed with sufficient fluids to carry the capsule into the stomach.<sup>23</sup>

Gastric lavage is also contraindicated in corrosive esophagitis because of the reflux of the caustic agent back into the esophagus and the possibility of esophageal perforation.<sup>3</sup> Airway obstruction, esophageal perforation, mediastinitis, and shock may be seen in the severely burned patient and must be treated accordingly.

When a child is brought to the emergency room or family physician with the history of caustic ingestion, the question always arises — Is there any esophageal damage? Contrary to what one might expect, the presence of burns in the oral cavity, drooling, and the odor of the ingested substance on the patient's breath are of little value in evaluating the condition of the esophagus. Only 25 to 50 per cent of patients with the foregoing symptoms have esophageal burns.<sup>7-10</sup> Conversely many cases have been reported where no oral burns were present, but in which the patient had corrosive esophagitis.<sup>4, 9, 11</sup>

The diagnosis is made by esophagoscopy. Since treatment must be instituted within 48 hours for optimal results, *early esophagoscopy* is mandatory. Because of "silent" burns, esophagoscopy should be done in all patients who have the history of ingesting a caustic, even though oral burns may be absent. The likelihood of perforation during esophagoscopy in the presence of an acute corrosive esophagitis is slight, particularly if the esophagoscope is not introduced past the burn.<sup>5, 6, 8, 10, 13</sup>

Definitive Therapy

When corrosive esophagitis is found, treatment consists of maintaining fluid balance, the use of steroids, antibiotics, and prophylactic bouginage.

The use of steroids in the early management of corrosive esophagitis is an adaption of the original work by Spain,<sup>14</sup> who demonstrated that in mice, cortisone slowed the fibroblastic and inflammatory response. However, to be effective the cortisone must be started within 48 hours after the injury.

Rosenburg<sup>15</sup> found that cortisone decreased the incidence of strictures in rabbits with esophageal burns but emphasized that an antibiotic must also be given to control suppurative complications. Weisskopf,<sup>16</sup> working with dogs, found that all of his animals developed esophageal strictures unless an antibiotic-steroid regimen was instituted.

Alford<sup>7</sup> reported 32 esophageal burns in humans that were not treated with steroids. In this group the stricture rate was over 50 per cent. Many clinical studies<sup>5, 6, 9-11, 17, 18</sup> have shown steroids to be of value in the prevention of esophageal strictures in patients who have ingested a caustic substance. In the

patients treated with steroids, the stricture rate runs from 0 to 11 per cent.<sup>5, 10, 17</sup>

Salzer first advocated bouginage for the prevention of esophageal strictures (1920). He started dilatation on the first day, or as soon as possible, believing that dilatation prevented the contraction of collagen fibers. Today, opinions vary regarding the use of dilatations in conjunction with the antibiotic-steroid regimen. Of those who advocate dilatations, some begin at once,<sup>4, 6</sup> others wait seven days until early collagen fibers are present,<sup>18, 20</sup> while still others await early stricture formation before starting dilatations.<sup>9, 11</sup> Some believe the use of antibiotics and steroids alone is sufficient.<sup>5, 10, 13, 17</sup>

Clinical Study

Between January 1961 and July 1964, 195 patients with suspected caustic ingestion were seen at the Children's Hospital in Columbus, Ohio. There were 106 males and 89 females. One hundred forty-six were Caucasian, 49 Negro. The majority of children (57 per cent) were within the 2 to 3 year age group, 26 per cent were under 2 years of age, 14 per cent were between 3 and 5 and 3 per cent were over 5 (Table 1). All of the ingestions were accidental

TABLE 1. Age Range of Children Ingesting Caustics

Under 2 years	2-3	3-5	5-10	Over 10
50 (26%)	112 (57%)	27 (14%)	4 (2%)	2 (1%)

except for one child who attempted suicide by drinking a cup of bleach (Clorox®).

Drano was the commonest agent ingested, but ammonia, lye, and bleach were also involved frequently. Potassium permanganate, lime, scouring bleach, water softener, and Clintest tablets accounted for occasional

TABLE 2

Agent Ingested	Number of Cases	Number of Oral Burns	Number of Esophageal Burns	
			1°	2°
Drano .....	123	114	6	11
Ammonia .....	20	19	1	5
Lye .....	19	16	0	5
Bleach .....	16	13	1	1
Potassium Permanganate .....	5	4	0	0
Na Lime .....	3	2	0	1
Oven Cleaners .....	3	3	0	0
Sulfuric Acid .....	1	1	1	0
Cresylic Acid .....	1	1	0	1
Scouring Bleach .....	2	1	0	0
Water Softener .....	1	0	1	0
Clintest Tablets .....	1	0	0	0

cases. Two patients ingested acids, one cresylic and the other sulphuric.

Of the entire group, all but 21 had burns of the lips, tongue, or pharynx. Esophagoscopy was done on all of the children within 48 hours. Thirty-four esophageal burns were found, 24 second degree and 10 first degree. There were no third degree burns (Table 2). Seven of the burns were circumferential.

In the group of 21 children with no burns of



the mouth or pharynx two esophageal burns were found. This 10 per cent incidence illustrates why *esophagoscopy should be done on all patients with the history of the ingestion of a caustic, whether oral burns are present or not.*

All agents ingested in this series were found to produce corrosive esophagitis with the exception of potassium permanganate, Clinitest, and scouring bleach. These agents, however, have the potential to cause esophageal damage.<sup>8, 21, 22</sup>

Patients with suspected corrosive esophagitis were admitted to the hospital and given a clear liquid diet. Parenteral fluids were given only if a child was unable to swallow because of oral burns. Esophagoscopy was done within 48 hours by a member of the Department of Otolaryngology. Children without esophageal burns, whose general condition permitted, were discharged on the following day.

The patients with second degree burns were treated immediately on a regimen of antibiotics and steroids. Children under 4 years of age were initially given prednisone (2mg/lb/day). This dosage was maintained four to six days and then gradually decreased over the next 10 days. Tetracycline was given in therapeutic dosage as long as the children were treated with steroids. In addition, 19 of these patients also received prophylactic bouginage. Esophageal dilatation with Hurst mercury-filled bougies was started on the day following esophagoscopy and was done daily for the first week. Dilatations were done in the majority of cases every other day for the next week, then twice a week, then once a week for one month. There were no complications associated with the use of steroids or bouginage during the acute phase of the burn. There were 10 first degree burns, eight received no further treatment, while two were treated with an antibiotic-steroid regimen (Table 3).

TABLE 3. Treatment of 34 Esophageal Burns

Severity of burn	No Treatment	Antibiotic-Steroid	Antibiotic-Steroid, Bouginage
1°	8	2	0
2°	0	5	19

Follow-up evaluation of the children who had esophageal burns was obtained in 30 (88 per cent). Of the 10 first degree burns, nine suffered no complications or sequelae. One was lost to follow-up. Four of the five patients with second degree burns treated only with antibiotics and steroids were traced. Two are normal and two have mild strictures. Of the 19 patients with second degree burns treated with antibiotics, steroids, and prophylactic bouginage, one developed a stricture. Fifteen are in good health, while three were lost to follow-up (Table 4).

The child that developed a stricture is a good example of the improper initial management of corrosive esophagitis. Her mother immediately induced repeated vomiting. Later a tube was passed, and her

stomach was lavaged. No further treatment was given until 48 hours later, when she was brought to the Children's Hospital. By then, the optimum time for the administration of steroids had passed. She subsequently developed a stricture, which was being treated with dilatations, when, three weeks after the burn, her esophagus was perforated with the Hurst dilator. Fortunately there were no complications secondary to the perforation, but at present her stric-

TABLE 4

Treatment		Results
None	(1°)	8 — no strictures
Antibiotic-steroid regimen	(1°)	1 — no strictures
		1 — lost to follow-up
	(2°)	2 — no strictures
		1 — lost to follow-up
Antibiotic-steroid regimen with bouginage		1 — mild stenosis controlled with regular dilatations 18 months post burn
		1 — difficulty in swallowing solids (probable mild stenosis) has not sought further medical treatment, 22 months post burn
	(2°)	15 — no strictures
		3 — lost to follow-up
	*	1 — stricture, being treated by retrograde dilatations 5 months post burn.

\*Initially treated with vomiting, gastric lavage, and penicillin, steroids not started until over 48 hours after the burn. A stricture developed. Esophagus later perforated with the Hurst dilator.

ture is being dilated by the retrograde method through a gastrostomy. This case illustrates the consequences of improper management and why the correct and early treatment of these lesions is so important.

Summary

1. Esophageal burns caused by the ingestion of caustic substances often lead to stricture formation if not properly treated.
2. The presence or absence of esophageal burns cannot be determined by physical examination.
3. All patients having a history of the ingestion of a caustic should be evaluated by esophagoscopy. The danger of perforation in corrosive esophagitis is slight, particularly if the esophagoscope is not introduced past the burn.
4. One hundred seventy-five children having oral lesions had a 20 per cent incidence of esophageal burns. In 21 others with no physical findings, the incidence was 10 per cent.
5. The induction of vomiting and gastric lavage is contraindicated when a caustic substance has been ingested.
6. Corticosteroids have been shown to decrease the incidence of stricture formation in corrosive esophagitis both in animal experiments and clinical studies. This drug must be started within 48 hours of the injury for optimal results.
7. Antibiotic coverage should be given as long as the patient is continued on steroid therapy.

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# The Clinical Value of Today's Radioisotope Scanning

D. BRUCE SODEE, M.D., and B. DI STEFANO, M.D.

RECENTLY radioisotope scanning has become practical on the small suburban hospital level, with the development of reliable commercial scanning devices, and the increased interest of the radiopharmaceutical industry in developing new nuclides. Organs which up until a few years ago could only be visualized by surgery or by elaborate radiographic means may now be outlined by the present-day radioisotope scanner. For example, the pancreatic diseases, which before had been such a diagnostic enigma, may be suspected by scanning the pancreas utilizing intravenously administered Se 75 tagged methionine.<sup>1,2</sup> Pulmonary embolizations which could only be visualized days after occurrence can now be visualized by scanning the lungs utilizing macroaggregate albumin tagged with I-131.<sup>3</sup> Renal tumors and cysts involving the cortex may be diagnosed before the calyceal system is involved, by utilizing chlormerodrin tagged with mercury 197.<sup>4</sup> Today, lesions of the brain may be suspected by doing the nontraumatic brain scan utilizing chlormerodrin tagged with mercury 197, on an outpatient basis.<sup>5,6</sup> These examples of the advances of radioisotope scanning will be presented with illustrative case reports.

## Pancreas Scanning

The radioactive selenium tagged methionine has been found to concentrate with selectivity in pancreatic tissue.

Over the last three years our group has been perfecting the methodology of the pancreatic scanning procedure. We have completed 200 pancreatic scans on over 50 patients. The recent introduction of the 5 by 2" sodium iodide crystal photoscanners enables us to detect lesions in the pancreas 1 cm. in size.

Selenomethionine does not concentrate well in pancreatic tumors nor in areas of pancreatitis. The different concentration of the nuclide between normal and diseased tissue has been found useful in the early diagnosis of pancreatic carcinoma and pancreatitis. Furthermore, we have correlated decreased concentration of isotope in the pancreas in cases of perforation of gastroduodenal ulcers in the

## The Authors

● Dr. Sodee, Cleveland, is Director, Nuclear Medicine, and Director, Professional Education, at Doctors Hospital, Cleveland Heights; Assistant Professor of Radiology, George Washington University, Washington, D. C.

● Dr. Di Stefano, Cleveland, is Chief Resident, Doctors Hospital.

organ. The complete procedure of pancreatic scanning has been reported elsewhere.<sup>2</sup>

Case No. 1. This 52 year old white man was admitted with a one month history of general malaise and anorexia followed by yellow discoloration of the skin, dark colored urine, and gray feces. He reported no contact with jaundice patients and no injections. There was no history of alcohol intake. His liver was felt  $2\frac{1}{2}$  fingerbreadths below the right costal margin and it was not tender. Total bilirubin was 26.30 mg./100 ml. and alkaline phosphatase was 9.1 units (normal values 0.8-2.3). Gastrointestinal x-ray series was reported normal. Obstructive jaundice was suspected. A pancreatic scan utilizing Selenomethionine-Se<sup>75</sup> revealed a filling defect in the superior portion of the head.

The patient was explored about 10 days after his admission. At surgery, it was noted that the intrapancreatic portion of the common duct revealed an irregular stricture. On palpation, the head of the pancreas presented a hard

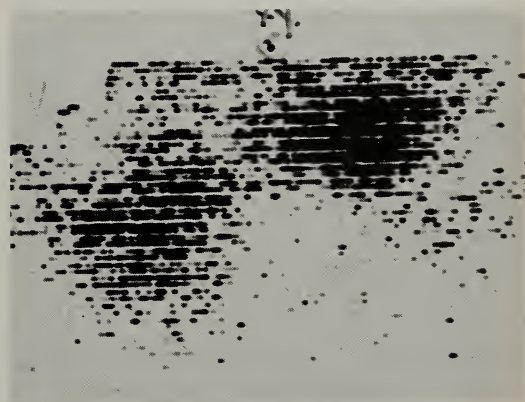


FIG. 1. Normal Pancreas.

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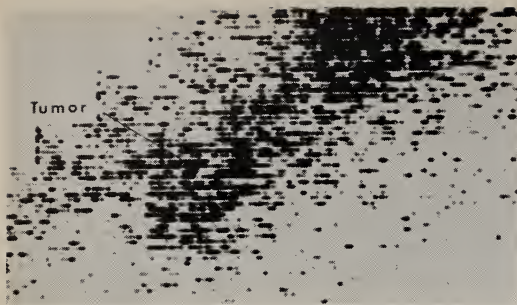


FIG. 2. *Pancreas of Case No. 1. The filling defect in the head is shown by the arrow.*

and crater-like sensation on the upper portion of the head. A repeated pancreatic scan done six months later showed increased size of the cold area. Metastatic disease was proven at biopsy to be pancreatic carcinoma. (Fig. 1 and Fig. 2.)

### Lung Scanning

George Taplin of UCLA first made practical the use of macroaggregate (MAA), heat treated human serum albumin tagged with I-131.<sup>7</sup> The particle of the aggregate is approximately 50 microns in size. When injected intravenously, these particles lodge

TABLE 1. *Radioisotope Scanning Procedures*

Organ	Radionuclide
THYROID	I <sup>125</sup> , I <sup>131</sup> , Tc <sup>99m</sup>
LIVER	Au <sup>198</sup> , Rose Bengal <sup>131</sup> Heat Treated Albumin I <sup>131</sup> Mo <sup>99</sup> , Hg <sup>197</sup>
SPLEEN	Cr <sup>51</sup> , Hg <sup>197</sup> MHPH <sup>197</sup>
KIDNEY	Chlormerodrin Hg <sup>197</sup>
BRAIN	Chlormerodrin Hg <sup>197</sup>
PANCREAS	Se 75 Methionine
PARATHYROID	Se 75 Methionine
LUNG	Heat Treated Albumin I <sup>131</sup>
TUMOR	Chlormerodrin Hg <sup>197</sup> Fibrinogen I <sup>125</sup> /I <sup>131</sup>
EYE	Chlormerodrin Hg <sup>197</sup>
BONE	Sr <sup>87</sup> , Sr <sup>85</sup>
BONE MARROW	Au <sup>198</sup>
HEART AND VASCULAR STRUCTURE	RISA <sup>131</sup> , Cholograffin I <sup>131</sup>
MYOCARDIAL	Cs <sup>131</sup>
PLACENTA	RISA <sup>131</sup> , Cr <sup>51</sup>

for a period of time in the arteriolar system of the lung, and approximately one hour after injection they leave the lung and go to the liver and spleen, where they are retained in the reticuloendothelial system. For this property, MAA has been utilized for the early diagnosis of pulmonary embolism. The area involved by embolus and/or infarction is a cold area on scan (no concentration of isotope), as no macroaggregate can pass through the vascular system. Dramatic cases have been reported where large emboli were surgically removed after the scan diagnosis. By doing this procedure early in suspected cases of

multiple pulmonary embolization, the diagnosis can be established and anticoagulation begun without delay.

Case No. 2. This 65 year old white man was admitted for evaluation of shortness of breath.

Initial chest x-ray revealed pleural effusion, and, after thoracentesis, an ill defined density was noted in the left hilar region.

Macroaggregate lung scan revealed two 3 by 4 cm. areas of nonconcentration in the left lower lobe. An over-



FIG. 3. *Normal Lung Scan. The liver can be seen in continuity with the right lower lobe.*



FIG. 4. *Lung Scan of Case No. 2. Note decreased to absent macroaggregate in the left lower lung.*

penetrating chest x-ray revealed densities in the same areas noted on the lung scan.

Biopsy of bronchial tumor revealed the areas to be anaplastic carcinoma. (Fig. 3 and Fig. 4.)

### Brain Scanning

The brain scan has been an investigational tool at large Universities for some time. However, with the onset of the large crystal commercial photoscanner and the development of commercially available inexpensive radiopharmaceuticals, this has become one of the most practical screening studies. With the



standard brain scan today we can detect brain tumors, areas of abscess, hemorrhage or infarction, subdural hematomas, and vascular anomalies, which include arterial aneurysms.<sup>8</sup> It has been said before that this is a screening study, and we cannot differentiate tumor from hemorrhage or abscess. However, by repeating the studies we can detect whether the malformation is vascular or not. The mercury tagged to chlormerodrin is injected intravenously and is excreted quite rapidly over a period of hours. In tumors or in areas of hemorrhage, mercury is retained for reasons now unknown.

TABLE 2. Clinical Indications for Scanning

Organ	
LUNG	Suspect Embolization
KIDNEY	Suspect Tumor { Malignant Cystic, Benign
BRAIN	Suspect Organic Disease { Tumors, malignant & benign Thrombosis Hemorrhage Abscess Subdural
PANCREAS	Suspect { Tumor Pancreatitis Penetrating Gastrointestinal Ulcer

Usually the patients with neurological complaints are observed for some time before a neurosurgical consultation is sought. With the brain scanning an early diagnosis can be established and further management undertaken. We think that this scanning procedure can help in screening the cases where carotid arteriography or pneumoencephalograms are indicated.

Case No. 3. This 62 year old white man had a one year history of frequent left sided occipital headaches with weakness and absence of sensation of the left upper extremity.

On admission, he was lethargic with about 50 per cent global aphasia and left hemiplegia. The electroencephalogram was reported abnormal, showing disturbance from the right occipital-motor-temporal regions. A brain scan with mercury 197 at one and 24 hours post dose revealed a localization of the isotope on the right in the area of the motor strip. It was interpreted abnormal with the most likely diagnosis of cystic glioma (Fig. 5).

A left cerebral arteriogram was performed and it was

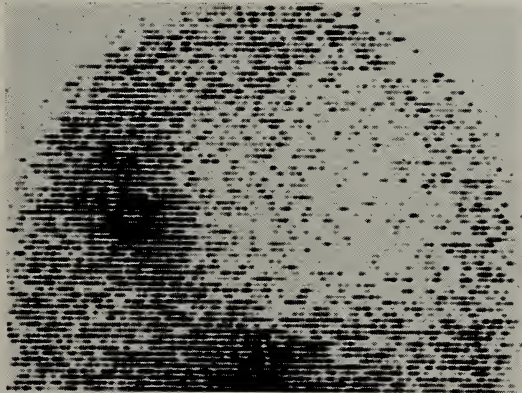


FIG. 5. Brain Scan of Case No. 3. Note the increased concentration of Hg. in the right side (where the tumor was found).

reported abnormal, suggestive of a space occupying lesion within the right parietal lobe. The patient underwent a craniotomy, and a cystic tumor was found in the right frontal parietal region. The neurosurgeon thought this to be a glioma, but a biopsy of the tumor proved it to be a metastatic carcinoma of unknown origin.

### Renal Scanning

It has been found that, when radioactive chlormerodrin is injected, about 10 per cent of it lodges in the renal tubular cells. Therefore, this radiopharmaceutical has been utilized for renal scanning.<sup>9</sup> Renal tumors, renal cysts, metastatic lesions, and areas of renal infarction do not retain this radiopharmaceutical as do the normal renal tubular cells.

Renal tubular lesions would be seen by intravenous pyelogram only when the calices are distorted. With the scanning procedures they can be detected long before such event occurs, and early treatment can be undertaken.

Case No. 4. This 64 year old white man was admitted with a one day history of right flank pain. This was accompanied by dysuria, chills, nausea, and vomiting. System review and past history were not contributory.

On physical examination the abdomen showed generalized guarding and tenderness of the right lower quadrant. The right costovertebral angle was also tender.

Intravenous pyelogram showed slightly delayed visualization of the renal pelvis on the left with contrast media ap-

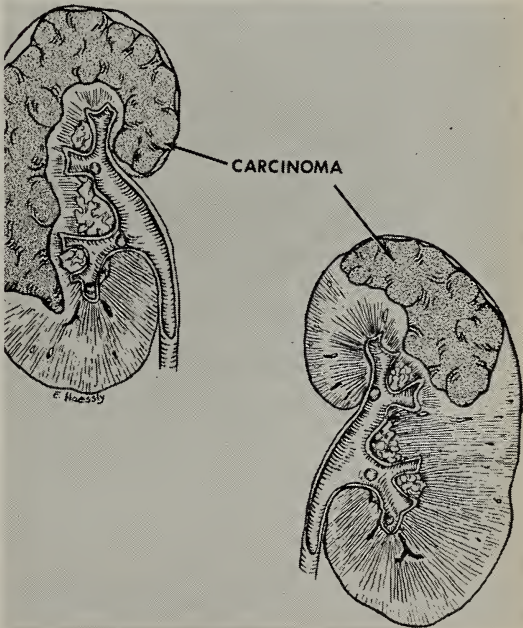


FIG. 6. Kidneys of Case No. 4.

pearing in the pelvis at approximately 20 minutes and still present at one hour. There appeared to be a moderate amount of function of the left kidney with some delay in appearance (Fig. 6).

Retrograde pyelogram showed the left upper urinary tract to be normal. On the right there was gross destruction of the calices. The superior calix was missing and apparently had been cut off. The middle grouping of calices failed to fill, and the inferior group was displaced downward and medially with deformity of the calices. The

findings were characteristic of deformity secondary to renal tumor. The tumor was extensive, invading the entire kidney.

Renal scan showed that the right kidney was not visualized and the upper and mid-portions of the left kidney were involved (Fig. 6A).

A renal arteriogram showed a large soft tissue mass occupying the mid-portion of the right kidney, leaving

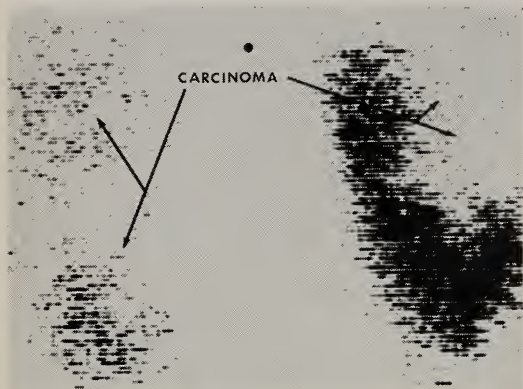


Fig. 6A. Kidney Scan of Case No. 4. The arrows indicate the areas of no mercury uptake.

only the inferior pole intact with normally functioning parenchyma. Also, a soft tissue tumor occupied the mid and lateral portion of the left kidney with abnormal vessels suggesting a malignant tumor.

About three weeks after admission the patient underwent surgery. A biopsy of the left kidney mass proved to be papillary tubular carcinoma.

#### DISCUSSION

Standard commercial scanning equipment and the technical skill to utilize this equipment are now available to any small suburban hospital. The nuclear medicine field has progressed to the point that the radiopharmaceuticals utilized for the above mentioned studies are inexpensive, and the radiation dose administered to the patient is less than that received during many x-ray examinations.

We have mentioned those nuclear medicine scanning examinations that are becoming popular as screening studies. The pancreas, which has always been a diagnostically difficult region, can now be visualized easily with the correct technique and instrumentation in approximately 90 per cent of the patients.

Pulmonary embolus and infarction, which could

only be suspected and not confirmed before, can now be found on all occasions by scanning the lung with heat treated albumin tagged with I-131. In all instances the patient can be started on corrective therapy immediately and, in a few instances, massive pulmonary embolus may be removed by a cardiothoracic surgical team and save human life.

The renal scan and the brain scan should now be more widely used. Both studies can be done on an outpatient basis and both studies will detect abnormalities before the standard clinical and radiographic studies. The screening brain scan should also be followed, when indicated, with the standard arteriography and air studies. However, with the brain scan we are viewing the exact anatomical size and location of the abnormality, while the radiographic studies reveal primarily displacement of cerebral structures by pathologic processes. The standard screening intravenous pyelogram or retrograde pyelogram only reveals calyceal distortion, but the radionuclide utilized in our renal scanning delineates cortical defects because it localizes in renal tubules. Therefore, cortical tumors or small cysts may be suspected with much more accuracy with the renal scan.

The foregoing diagnostic scanning procedures are only a few of our armamentarium. As more general physicians become acquainted with this field many more patients will be given the proper diagnosis and the proper therapy long before other standard diagnostic procedures reveal disease.

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THE ART OF THE PRACTICE OF MEDICINE. — Each of us needs to be reminded from time to time that interest in disease processes and scientific knowledge may obscure the patient as an individual — an individual with a personality and a shrewd ability to appraise his medical attendants. How careful one must be to inspire trust and confidence by the kindly consideration of the patient and especially at times when he is at low ebb and when the slightest considerations are valued far beyond their apparent worth and when lack of consideration has the opposite effect. — Garfield G. Duncan, M. D., Philadelphia: *Military Medicine*, 126:355-358, May 1961.



# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

C. R. MACPHERSON, M.D., *President*

## PRESENTATION OF CASE

**F**IRST ADMISSION: A Negro woman, aged 48, entered University Hospital with a chief complaint of shortness of breath on exertion which she first noted about one year prior to admission. At this time she also woke up occasionally suddenly at night short of breath and her breathing would improve when she sat up. Her first episode of shortness of breath occurred at the time she had a "flu" characterized by nasal congestion, cough, and sore throat. Her shortness of breath on exertion increased markedly one week prior to admission, and she had severe paroxysmal nocturnal dyspnea. The patient had had the usual childhood diseases, pneumonia once, but denied having had tuberculosis, diphtheria, or rheumatic fever.

On physical examination, her blood pressure was 120/80, pulse rate 92 per minute and regular, respiratory rate 24/min., temperature 98°F. She was well nourished but appeared acutely and chronically ill, and was sitting up in bed, coughing. Her chest had dullness in both bases and rales over both lower and mid-lung fields. The point of maximal impulse of the heart beat was 9 cm. from the midsternal line; the second pulmonic sound was louder than the second aortic sound. A soft, Grade II midsystolic murmur was heard at the base; no diastolic murmurs were heard. The liver was 4 cm. below the right costal margin; no other organs or masses were palpable. There was 2 plus pitting edema of the extremities.

Her hemoglobin was 11.6 Gm., the hematocrit 40 per cent, the white blood cell count 6,600 with 58 per cent lymphocytes. The urine had a specific gravity of 1.006 and showed 10 mg. of protein, many white cells and 0 to 4 red cells. The blood urea nitrogen was 13 mg./100ml., the fasting blood sugar 84 mg. The CO<sub>2</sub> combining power was 60 vol./100 ml. The serum glutamic oxalacetic transaminase (SGOT), the glutamic pyruvic transaminase (SGPT), the serum sodium, potassium, chloride, bilirubin, total protein, albumin/globulin ratio, inorganic phosphorus, antistreptolysin O titer, and the prothrombin

## Presented by

- Charles F. Wooley, M.D., Columbus, and
  - Emmerich von Haam, M.D., Columbus;
- Edited by Dr. von Haam.

time were all within normal limits. Fluid removed by thoracentesis contained 9,100 red blood cells and 500 white blood cells per cu. mm.; 91 per cent of the white cells were lymphocytes; the specific gravity was 1.010; culture was negative. Radioactive iodine uptake in 24 hours was 28.1 per cent. Several lupus erythematosus (LE) preparations, latex fixation tests, and blood cultures were negative.

Chest x-ray and cardiac fluoroscopy showed an enlarged heart and bilateral pleural effusion; the pulsations were somewhat diminished in amplitude. The appearance was not characteristic for pericardial effusion. There were areas of atelectasis mainly in the left lung fields. Repeat chest x-ray showed some reduction in the pleural fluid on the right and slightly reduced pulmonary vascularity throughout both lung fields. The possibility of multiple small pulmonary emboli could not be excluded. The electrocardiogram showed a complete left bundle branch block.

The patient received digoxin and diuretic therapy with loss of 23 lb. and marked improvement of her symptomatology. She was discharged to continue therapy on digitalis leaf, 0.1 Gm. daily.

## Second Admission

A year later the patient was admitted for a transcarotid coronary angiogram. It was interpreted as normal. There were no appreciable changes in the physical findings or laboratory tests from the previous admission. She was discharged on digitalis leaf, 0.1 Gm., and Diuril,<sup>®</sup> 500 mg. daily.

## Third Admission

Three years later the patient was readmitted with complaints of nausea, epigastric pain, and shortness of breath. She had done relatively well in the in-

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terim on digitalis and diuretics until about one month prior to admission, when she again noted increased fatigability, shortness of breath, chronic cough, paroxysmal nocturnal dyspnea, and swelling of both ankles. Her blood pressure was 120/58, pulse rate 108, respiratory rate 20 per min., temperature normal. The chest had bilateral basal rales. The heart was enlarged and had sinus tachycardia; the point of maximal impulse was somewhat diffuse. A Grade II blowing systolic murmur was heard at the apex and a loud presystolic gallop was present. The liver was down 5 fingerbreadths and was slightly tender. The extremities showed 1 to 2 plus pitting edema. All her laboratory tests were normal. Cardiac output determinations showed normal right ventricular and right atrial pressures; the cardiac index was decreased, and the injection time index was definitely reduced. Electrocardiograms showed a persistent left bundle branch block. The patient lost 6 lb. and was discharged to continue on diuretics and digitalis therapy.

#### Fourth Admission

She was again admitted a month later with signs of increasing heart failure. She had also noted mid-epigastric pain not related to meals or exertion. Since discharge she had noted marked weakness.

Her blood pressure was 105/85, pulse rate 112, respiratory rate 20, temperature normal. The neck veins were slightly distended, filling from below. The lungs were clear. The point of maximal impulse of the heart was in the anterior axillary line; a Grade II blowing holosystolic murmur was heard over the apex and radiated to the left axilla. A mid-systolic ejection click was heard in the pulmonic area. There were protodiastolic and presystolic gallops. The first heart sound seemed very soft. The liver was down 2 fingerbreadths, and the patient had associated slight right upper quadrant tenderness. The extremities showed 2 plus pitting edema.

The urinalysis and blood count were normal. The blood urea nitrogen was 40 mg., total protein 5.4 Gm. with albumin of 3.0 and globulin of 2.4 Gm. The serum CO<sub>2</sub> was 23, sodium 124, potassium 4.5, and chlorides 88 mEq./L. Alkaline phosphatase was 5.9 units, inorganic phosphorus 2.1 mg./100 ml. The total bilirubin was 2.6 with a direct of 1.6 mg. Chest x-ray showed cardiomegaly without evidence of congestive heart failure. The electrocardiogram was unchanged.

Because of the possibility of pulmonary emboli she was given anticoagulant therapy; her abnormal electrolytes were corrected, and treatment was continued with potassium, digitalis, and diuretics with little weight loss. On repeat chest x-ray, the heart showed no appreciable change, but the possibility of a pericardial effusion was considered. She continued to do rather poorly. The blood pressure was 120-100 systolic until her eleventh day when it suddenly fell to 40/0. She remained alert but complained of shortness of breath. Her blood pres-

sure did not respond to vasopressors. Four hours after this hypotensive episode she had cardiac arrest with no response to resuscitative efforts.

#### CLINICAL DISCUSSION

DR. WOOLEY: The problem here is that of a middle-aged Negro woman who developed cardiac symptomatology following a flu-like illness. This manifested itself by cardiomegaly, recurrent congestive heart failure, gallop rhythms, and the development of murmurs of mitral regurgitation. Her electrocardiograms consistently showed a conduction defect described as complete left bundle branch block. After some initial response to therapy she developed recurrent congestive failure complicated later probably by multiple pulmonary emboli. The usual causes of heart disease and heart failure were absent, and there was a little additional objective information in the fact that her coronary arteries were demonstrated *in vivo* to be normal. I will now ask Dr. Dunbar to comment on the x-rays.

DR. DUNBAR: The initial films were made in 1959, when she came in with a generalized cardiac enlargement and obviously bilateral pleural fluid. In the films a year later the heart remained large, without specific characteristics. The coronary arteriograms done in 1960 showed normal coronary arteries and evidence of left ventricular enlargement since the network of the left coronary artery was considerably extended and the descending branch was wider than the right coronary branch. We did not see aortic regurgitation or evidence of stenosis of the aortic valve. Cardiac fluoroscopy in 1962 showed the heart somewhat larger than in 1960. The enlargement was still nonspecific except that the left atrium was slightly more enlarged. This does not necessarily mean mitral valve disease in the face of an enlarged left ventricle since the left atrium may be injecting against a high end diastolic pressure, or there may be a relative insufficiency of the mitral valve.

The last film was four or five days before death. The heart had continued to enlarge. We were never able to demonstrate any pericardial fluid. So all I can offer is a big heart, normal coronary arteries, and probably normal valves. I would therefore think in terms of myocardial disease, and we did mention adult fibroelastosis at one point.

DR. WOOLEY: I saw this patient in 1960 and brought her into the hospital for the arteriogram to attempt to substantiate a clinical diagnosis that we had already made. The story after 1960 was unknown to me. The problem was whether or not we can make a diagnosis of myocardial disease *in vivo*. We'll start out to see if our findings in this patient match the problems of primary myocardial disease.

Chronic myocarditis was a frequent diagnosis at the turn of the century and during the first two decades of this century. Most elderly patients who died had



"chronic myocarditis" written on the death certificates. Gradually, appreciation of the fact that hypertensive and coronary artery disease were more frequent causes of congestive failure led us to drop this diagnosis more or less. In the 1930s and 1940s Saphir's was one voice furthering the cause of myocarditis, and he emphasized that myocarditis could not be diagnosed on gross examination alone. In 1950 Henry Christian<sup>1</sup> enumerated the frequency with which myocardial lesions occurred with infections and stressed the vulnerability of the myocardium, noting that minor lesions of the myocardium could result in serious disturbances of its function. I will use the terms myocardopathy or cardiomyopathy or primary myocardial disease somewhat interchangeably since I think it is impossible to separate these terms at the present time.

### Primary Myocardopathy

In general, these are patients with cardiomegaly, heart failure, and symptoms primarily involving the myocardium in the absence of coronary, hypertensive, or valvular disease. There has been some definition histologically, but the definition of this process at the cellular level is still missing. Since the defects involving the production, conservation, and utilization of myocardial energy have not yet been precisely defined, the stimuli to the production of hypertrophy are still poorly understood. These diseases referred to collectively as cardiomyopathy or primary myocardial disease represent a heterogeneous group with primary myocardial involvement as the only recognizable factor. While the patients constitute only a small percentage of individuals with heart disease, this condition is not a rare clinical picture.

The etiologic background is broad with multiple and somewhat arbitrary classifications. Dr. Eugene Robbin<sup>2</sup> classifies the myocardopathies as those associated with infections, systemic inflammatory and noninflammatory diseases, metabolic and nutritional disorders, hypersensitivity reactions, toxic conditions, muscular and neuromuscular diseases, and finally those of unexplained etiology. Among the rare conditions producing a variety of degrees and types of myocardial involvement are sarcoid and amyloidosis. To this list of etiologic factors it might be wise to add alcohol and pregnancy. The association of high alcohol intake over a long period of time with the development of a certain type of clinical pattern of heart disease is so common that an etiologic relationship between them seems probable. The nature of the postpartum myocardial problems on the other hand is a matter of great dispute at the present time.

As far as the clinical symptomatology is concerned, I recommend the classification of the various clinical types of cardiomyopathy by Goodwin.<sup>3</sup> The most common group is characterized by cardiomegaly, congestive failure, and atrioventricular valvular incompetence. It usually has an insidious onset, and its

duration is usually from one to two years. Clinical symptoms include dyspnea and cardiac pain, with edema, elevated jugular venous pressure, murmurs of tricuspid or mitral regurgitation, cardiomegaly, and gallop rhythm. Electrocardiograms may show evidence of hypertrophy, rhythm disturbances, and frequently bundle branch block. I would suggest that our patient fits into this category of the clinical types of cardiomyopathy described by Goodwin.

### Diagnosis

Let us briefly consider some of the diagnostic aspects. The auscultatory phenomenon will depend on the clinical classification, and we may have murmurs of mitral or tricuspid regurgitation, or outflow tract murmurs suggesting aortic or pulmonic stenosis. There may be changes in the electrocardiogram related to a conduction defect, and quite frequently there may be gallop rhythm. Virologists have helped us by recognizing a viral etiology as in the case of influenzal myocarditis. Hemodynamic studies frequently are also helpful in excluding other types of heart disease for which surgical therapy may be available.

In the realm of diagnostic procedures there is great interest apparently in biopsy procedures. This enthusiasm at the present time is not substantiated by the results. The problem is to make a diagnosis from this bit of tissue when I think Dr. von Haam will assure you that it is sometimes difficult when given the entire heart. It may be that as histochemical and biochemical studies improve, and as we have better knowledge of the myocardial metabolism and its enzyme systems, we may use the information from a biopsy for a more precise diagnosis in some of the more baffling cases. We did comment on the role of coronary arteriography. I am not aware of many studies in which coronary arteriography has been used in the differential diagnosis of primary myocardial disease, but in cases such as ours today we think it offers appreciable assistance in many respects.

### Therapy

The therapy of these different myocardopathies is obviously complex because it depends upon the etiology and the problem with which one is faced, so that the correct classification and correct understanding of the etiology are absolutely necessary for the correct choice of treatment.

Now to get back to our case, I would say that the primary diagnosis in this patient would be myocardial disease the exact etiology of which is uncertain. It is quite probable that this woman suffered multiple pulmonary emboli through the latter part of her life, and I would raise the possibility of a terminal pericardial effusion although there was no pericardial effusion present during her earlier hospital course. I would put this case in the first group of Goodwin's classification and call it a primary myocardial disease

or myocardopathy of undetermined, but probably infectious, origin.

### General Clinical Discussion

DR. VON HAAM: I would like to hear some comments on the electrocardiogram.

DR. WOOLEY: The electrocardiogram demonstrated a conduction defect designated as complete left bundle branch block. It fits perfectly with our clinical diagnosis. Unfortunately conduction defects are nonspecific and they may appear in myocarditis associated with diphtheria, in senescent heart disease, and in nonspecific myocardial fibrosis.

QUESTION: Was a left ventricular anigiogram done?

DR. WOOLEY: This was not performed. The patient subsequently developed the murmur that would sound as though it represented valvular regurgitation. This again is characteristic of the group of patients with myocardial disease. It also will occur in coronary disease when papillary muscles are involved.

QUESTION: Why did Dr. Dunbar mention fibroelastosis?

DR. DUNBAR: I mentioned it as I was just groping for a diagnosis.

QUESTION: Dr. Wooley, if this woman had not had a coronary arteriogram, could her entire symptoms be explained by dysfunction of the papillary muscle caused by a silent infarct? Would a normal coronary arteriogram rule out this possibility?

DR. WOOLEY: At the present state of our knowledge and technic it does not exclude coronary artery disease. The arteriogram tends to underestimate, at the present time, the severity of coronary disease.

DR. VON HAAM: Does it rule out occlusion?

DR. WOOLEY: One would hope yes, if the technic is good.

DR. GWINUP: It's probably worth mentioning that amyloid heart disease is not unusual in the South or in the big city hospitals where one takes care of large Negro populations. It affects predominantly young Negro males, and in Baltimore it is called Osler II disease because Osler II is the Negro ward at Johns Hopkins, while in New York it is called Harlem heart.

DR. WARREN: It just struck me that at certain times the circulation time may be helpful in answering the question: Could there be pulmonary emboli?

DR. WOOLEY: The problem of pulmonary emboli is really bothersome. There are two technics that may be helpful. One is pulmonary angiography, and the second technic is the use of scanning procedures after injection of radioactive substances.

DR. MARABLE: I don't think you can rely on circulation time to give you any reliable information about emboli unless they are truly massive, and cause failure rather than actual obstruction.

DR. WARREN: When anybody presents himself with this picture of intractable heart failure he ought to have cardiac catheterization.

DR. WOOLEY: I would say that you should consider any additional diagnostic technics and decide on the basis of the individual problem that presents itself: Do we have a remedial type of lesion or is there a remedial type that could be effectively excluded by diagnostic procedures?

QUESTION: You stated that these patients live approximately two years. I am sort of confused as to the five-year survival of this patient.

DR. WOOLEY: This woman was 52 and her symptomatology began at 47, and Dr. Goodwin mentions the fact that the average deterioration of the patients is from one to two years. Obviously this can be a lot longer, and if this unknown biochemical insult is not permanent, there is apparently no reason why some of these patients cannot recover.

### CLINICAL DIAGNOSIS

1. Primary myocardopathy of undetermined origin.
2. Possible pericardial effusion.
3. Possible multiple pulmonary emboli.

### PATHOLOGIC DIAGNOSIS

1. Myocardopathy of undetermined origin with (a) diffuse and perivascular myocardial scarring, and (b) mild fibroelastosis.
2. Multiple pulmonary emboli with pulmonary hypertension.
3. Questionable sickling tendency.

### DISCUSSION OF PATHOLOGY

DR. VON HAAM: The body was well developed and well nourished. It showed marked edema of the skin, particularly on both lower extremities. The abdomen was distended and contained approximately 1000 cc. of clear yellow fluid. The heart was enlarged and weighed 520 grams. All chambers were dilated and we found no deformities of any of the valves. The right atrium contained a tightly attached mural thrombus. All coronary vessels were patent and showed only a minimal degree of sclerosis. The lungs appeared moderately well aerated and showed no evidence of emboli or infarction. The liver was brown and revealed a typical nutmeg pattern superimposed by acute congestion. The remaining organs revealed no gross abnormalities.

Microscopic section of the heart showed hypertrophy of the muscle fibers of both ventricles, some fine perivascular scarring, and some diffuse interstitial fibrosis. The endocardium was thickened and showed a patchy increase of endocardial elastic fibers. Small organized thrombi were present in the interstices of the trabeculae. Microscopic examination of the lungs showed some thickening of the pulmonary vessels and small, well-organized thrombi in many of the lumina. The liver showed large central blood lakes as found in acute congestion due to right heart fail-



ure. The kidneys appeared congested, and the red blood cells within the lumina of the blood vessels showed evidence of sickling. This was the only place in which this phenomenon was present.

The diagnosis at the autopsy was idiopathic myocardial hypertrophy, a diagnosis which is now made less and less frequently since we are usually able to explain the etiology of the myocardial hypertrophy present. In this case I consider it as a response to a myocarditis of undetermined origin, which was responsible for the fine interstitial fibrosis, the perivascular scarring, and the fibroelastosis. The latter was not as severe as found in children, but it was definitely present and also was probably responsible for the numerous small mural thrombi which in turn had caused showers of small pulmonary emboli.

The complete freedom of the heart valves from any

inflammatory process and the normal appearance of the coronary vascular tree suggest that we are dealing indeed with a myocardopathy as diagnosed by our clinical discussant. The phenomenon of the sickling, which we observed in one organ only, cannot be taken too seriously, although a sickling tendency can be responsible for myocardial lesions since it causes anoxia in many organs. I can only speculate upon the etiology of her myocardopathy, but the presence of a few foci of inflammatory cells in the adventitia of the aorta and in the septum of the myocardium would imply an inflammatory or possibly viral origin.

## References

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3. Goodwin, J. F.; Gordon, H.; Hollman, A., and Bishop, M. B.: Clinical Aspects of Cardiomyopathy. *Brit. Med. J.*, 1:69, 1961.

**E**PIDEMIC INFLUENZA is caused by members of a family of closely related but distinct viruses, the most important of which are designated influenza viruses A, A<sub>1</sub>, A<sub>2</sub>, and B. The properties of these viruses do not remain constant but change from time to time in unpredictable ways. Thus, the protection provided by influenza vaccines depends upon representation in the vaccine of current influenza virus strains. The Public Health Service is constantly looking for any evidence of change in the antigenic composition of influenza viruses as these viruses are isolated from patients during various outbreaks. When it is apparent that a particular strain has changed to the point at which little or no protection will be provided by the current vaccines, as when a new strain or type emerges, a complete change of strain composition of the vaccine is called for.

A slight change in the composition of influenza vaccine for the 1965-1966 season was announced May 2, 1965 by Dr. Luther L. Terry, Surgeon General of the Public Health Service. In addition to the representatives of the four influenza virus strains — A, A<sub>1</sub>, A<sub>2</sub>, and B — which are used in the current vaccine, next season's formula will include another A<sub>2</sub> strain, isolated in Taiwan in 1964. This strain is closely related to the A<sub>2</sub> strain which has been associated with epidemic influenza during the past season. The licensed influenza vaccine manufacturers have been advised by the Service's Division of Biologics Standards of the addition of the Taiwan A<sub>2</sub> strain for the 1965-66 season.

Three A<sub>2</sub> influenza strains were responsible for influenza epidemics in various parts of the world during 1964. Of the three candidate strains, the Taiwan/1/64 had the most desirable properties. It showed broader coverage than the other two, it had greater antigenicity in animal and clinical tests, and was considered suitable for production.

After careful consideration of the data, the Division of Biologics Standards advised the manufacturers to proceed with the manufacture of a vaccine in which the A<sub>2</sub> influenza virus strain representation is equally divided between Japan/170/62, the current A<sub>2</sub> representative in the vaccine, and Taiwan/1/64. The present recommendation for the strain composition of the vaccine for the 1965-66 season is as follows:

A	PR8	100 CCA
A <sub>1</sub>	Ann Arbor/1/57	100 CCA
A <sub>2</sub>	Japan/170/62	100 CCA
A <sub>2</sub>	Taiwan/1/64	100 CCA
B	Maryland/1/59	200 CCA

"It is clear that we continue to be in a period of antigenic change," Dr. Terry said, "and that examination and analysis of the strains isolated in this country and abroad during the current season, or later in the present year, may call for further recommendations."

# Maternal Deaths Involving Pulmonary Embolus

By the OSMA COMMITTEE ON MATERNAL HEALTH

## With Comment of Consulting Obstetrician and Gynecologist

PUBLISHED annual reports of this Committee for seven years (1955-1961) have stressed the prevalence of maternal deaths in Ohio due principally to hemorrhage, infection, and toxemia. However, under the classification of "Other Causes," maternal deaths from *pulmonary embolism* lead this miscellaneous group, with 61 deaths out of 454 reported in *this* column. Therefore, the Committee considers it timely to present three cases representing deaths in this category. One is associated with ectopic pregnancy, one with spontaneous abortion and the third patient died undelivered.

### Case No. 371

This patient was a 35 year old, white, Para VII, abortus III, ectopic I, who died two days postlaparotomy (ectopic). Several facts in her past history are available; there were seven term pregnancies, details of which are not recorded. The patient had a dilatation and curettage for each of three "miscarriages"; there was a vague history of pelvic "inflammation." About March 8 the patient was seen by her family physician after she "passed out"; this was preceded by a sudden, diffuse, sharp, lower abdominal pain, greater on the right side, referred to the shoulder. She had missed no periods. Her physician diagnosed the case "gall bladder disease"; details of his findings and treatment were not recorded. On March 15 the patient had a profuse period with clots, lasting two weeks.

On March 30, at 7:30 p.m., severe abdominal pain reappeared with nausea, vomiting and diarrhea. In the emergency room at 8:30 p.m. her complaints were severe abdominal pain, with vaginal bleeding during the past 12 days. A catheterized urine and hemogram were normal; the differential count was normal. Treatment was not recorded. Four hours later the patient was admitted; the abdomen was extremely tender and vaginal examination gave the impression of an adnexal tumor (ovarian cyst?). At 4:30 a.m. lower abdominal pain recurred, referred to the *right* shoulder. Vital signs were normal. The hemoglobin was 61 per cent; erythrocytes 3.14 million; leukocytes 7,600.

Treatment was reported as "symptomatic." On April 1 "bright vaginal bleeding" appeared, but the patient "had a good day"; one unit of blood was administered. The next day the patient submitted to a dilatation and curettage

(meager tissue) and laparotomy. The operation revealed an hemoperitoneum with old, free blood walled off around the left uterine tube containing a tubal pregnancy. The right uterine tube appeared "inflamed." Bilateral salpingectomy and (Coffey) suspension of the uterus were performed, with incidental appendectomy. One unit of blood was given. The immediate postoperative course was uneventful, according to records.

Suddenly on April 4, at 8:30 a.m., the patient went into shock, was cold and clammy. Chest examination was negative. Parenteral fluids were given with no improvement. On the assumption that a "vessel had begun to bleed," a second laparotomy was performed. Only residual blood was found in the pelvis; ovarian vessels were re-ligated; more blood was ordered. The cause for shock was never ascertained. In the recovery room, postoperatively, the patient became cyanotic, developed convulsions, became pulseless and died at 5:20 p.m., April 4. Autopsy was permitted.

*Cause of Death (Autopsy):* Recent bilateral salpingectomy and appendectomy for ruptured ectopic pregnancy; shock, clinical, cause unknown; pulmonary edema; pulmonary embolus, acute, pulmonary artery; multiple retention cysts, kidneys.

### Comment

With interest, the Committee reviewed and studied the chronological events in the case. Members felt that (in retrospect) there was some delay in further investigating the problem between the date of her admission (March 30) and April 2, e.g., culdocentesis, especially in the light of a diminishing hemoglobin. At least, the laparotomy should have been performed sooner. After due deliberation, however, the Committee voted this a nonpreventable maternal death.

### Case No. 412

This was a 42 year old, colored, Para IV, abortus II, who died seven weeks postabortal. Very few details are known concerning her past history. There were four term pregnancies and one abortion without dilatation and curettage. In February the patient had an episode of "pleurisy" in the left side of the chest with marked "tightness" and dyspnea. The following May 29, she spontaneously aborted an early pregnancy at home, unattended. Again, details are not known. On July 9 (six weeks later) the patient again suffered chest pain; she was seen in the emergency room and sent home. The same day, as the chest pain increased she returned to the emergency room and was admitted to the hospital with dyspnea, temperature 99°; pulse rate 120/min.; respiratory rate 26/min.; blood pressure 100/72. On July 12, the chest x-ray revealed no intrathoracic disease. The electrocardiogram was normal except for tachycardia

A continuous state-wide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.



but (four days later) July 13 it revealed active myocardial changes and a diphasic T-wave. The urine and blood urea nitrogen were normal. Reaction to the Kahn test was 2 plus positive; hemoglobin was 8.9 Gm.; erythrocytes 3.51 million; leukocytes 7,100.

July 13, the patient was digitalized. Blood culture showed no growth. On July 16, she received Achromycin® and diathermy; x-ray showed pneumonia at left lung base. July 21, while she was in the bathroom, the patient developed acute chest pain and collapsed. She was given aminophylline, morphine, and a Levophed® "drip," but promptly died. Autopsy was performed.

**Cause of Death (Autopsy):** Bilateral pulmonary infarction; pulmonary artery embolus; thrombosis of right uterine vein. (NOTE: Apparently, the patient developed phlebotrombosis affecting her uterine veins as a direct result of the spontaneous abortion. An embolus discharged from the thrombus of the uterine vein probably lodged in the pulmonary artery from which a thrombus formed and which extended to secondary and tertiary bronchi, causing complete occlusion. Pulmonary infarction resulted; death was due to cerebral anoxia.)

### Comment

This case provoked considerable interest and prolonged discussion among Committee members. Patient responsibility was entertained on grounds that the patient did not seek medical attention following her abortion May 29th; none was reported. On the other hand evidence of examination, diagnosis and treatment in the emergency room, July 9, are lacking for her first visit. Furthermore, it appears that the diagnosis of embolus was never entertained after her hospital admission; nor was the use of consultation and/or anticoagulants considered. By a narrow vote, the Committee voted this a nonpreventable maternal death.

### Case No. 388

This patient was a 23 year old, white, primigravida, who died undelivered in her 38th week of gestation. Besides pyelitis a year before, her past history was not remarkable. With a last menstrual period September 4, she registered with the clinic in her fourth month and made six visits. Edema developed at 36 weeks responding to diuretic therapy and diet. Blood pressure and urine remained normal. On May 26 at 2:23 a.m., the patient was brought to the emergency room, unconscious 90 minutes, with blood pressure in shock levels. (The husband said she had been unconscious several hours on May 25, without convulsions.) The uterus was tense, fetal heart sounds absent. Blood clotted normally in five minutes. Therapy consisted of parenteral 5 per cent glucose solution containing one ampule of Levophed, and nasal oxygen. As the obstetric resident was called the blood pressure rose to 100/50.

At 3:20 a.m. the patient was admitted, and placed on the delivery table. With a working diagnosis of abruptio placentae, an amniotomy was done; the cervix was 4 cm. dilated, 80 per cent effaced, station "0," head presenting. Plasma was pumped in under pressure, awaiting a cross match on blood. Fifteen minutes later the patient stopped breathing and the heart beat disappeared. Quickly a thoracotomy was performed and cardiac massage initiated; oxygen was administered by intubation. All measures failed; the patient was pronounced dead at 4:15 a.m. May 26. Autopsy was performed.

**Cause of Death (Autopsy):** Multiple pulmonary emboli, recent; multiple focal renal infarctions, old and recent; uterine and placental infarctions, old.

### Comment

The Committee reviewed this case with keen interest, remarking that clinical features were well reported. Apparently, the constant attention and

management indicated ideal care. However, members wondered if the pathologist discovered abnormalities in veins of the pelvis and lower extremities, or if they were not explored. Further, a question was raised concerning medical findings following her initial spell of unconsciousness May 25. The Committee voted this a nonpreventable maternal death, unavoidable catastrophe.

### Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was furnished at the request of the Committee:

"Pulmonary embolism is probably the most fearsome, frustrating and horrifying complication of all postpartum and postoperative complications simply because of its unpredictability and the speed with which it can and usually does produce a fatal outcome. Almost invariably those cases destined to end fatally have reached that point in a matter of minutes, long before anything more than a tenuous tentative diagnosis can be arrived at, in most cases even before competent medical assistance can be summoned, much less reach a reasonable and tenable conclusion.

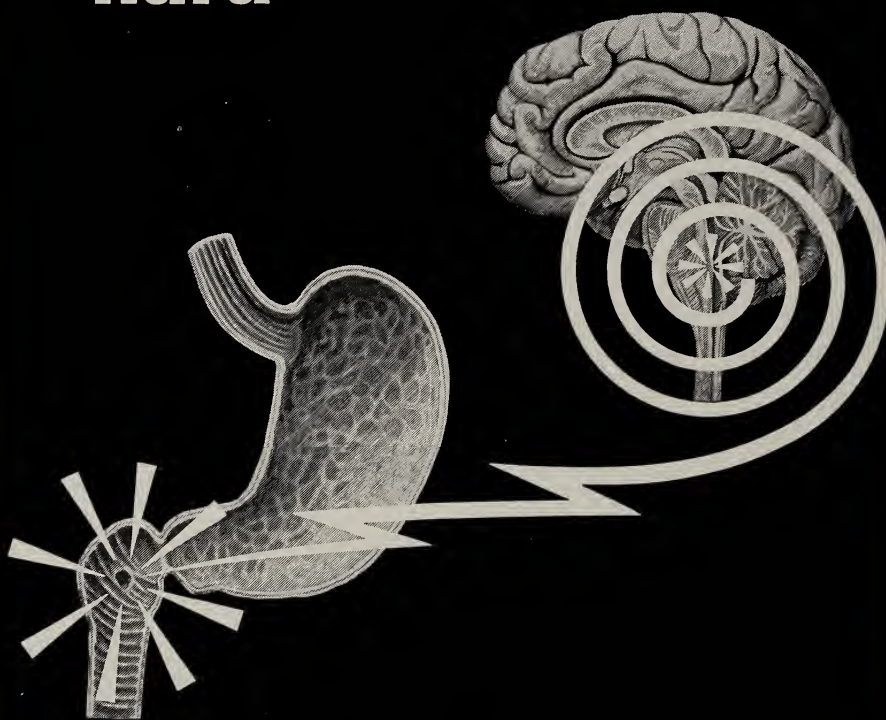
"The dictum, 'first be sure to do no harm' applies with extraordinary meaning in these cases. Perhaps it is just as well that the index of suspicion is no higher and the course of the condition no shorter. One shudders to think of the needless surgery with its complications and morbidity that could result from mistaken diagnosis in such cases and most of the prophylactic measures that have been suggested, if commonly utilized, would not only be wasted but might themselves produce more over-all harm than is done by the condition they are supposed to prevent.

"It must be remembered that small emboli may pass unnoticed, multiple small emboli may or may not produce symptoms and an embolus obstructing the main pulmonary artery is almost invariably fatal before any sensible lifesaving procedure can be instituted.

"Mild cases involving only the right or left branch of the pulmonary artery will probably cause faintness, pain in the chest, arms or upper abdomen, cyanosis and dyspnea, tachycardia and shock. In these cases immediate use of anticoagulants, oxygen and narcotics may arrest the process and prevent a fatal outcome. Early and active ambulation is the only really reasonable prophylaxis.

"Any statement that any death from pulmonary embolus is preventable imposes a heavy burden of proof on the person (or Committee) making the statement. In most such instances including those presented herewith it may be readily possible to show that care was less than ideal, but demonstrating *beyond a reasonable doubt* where improvement of the care would have altered the outcome is another matter entirely."

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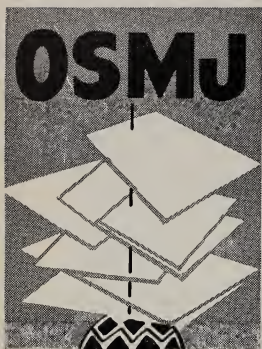
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# NEWS AND *Organization Section*

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## Proceedings of The Council...

### A Report of Actions Taken and Policy Established at Regular Meeting Held in Columbus on July 24 and 25

A REGULAR MEETING of The Council of the Ohio State Medical Association was held on July 24 and 25, 1965, at the Sheraton Columbus Hotel, Columbus. Those present at the meeting were as follows: All members of The Council except Dr. B. C. Diefenbach, Councilor of the Seventh District and Dr. Robert C. Beardsley, Councilor of the Eighth District; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Dr. John H. Budd, Cleveland, chairman of the Ohio delegation to the AMA; Mr. George H. Saville, consultant to the OSMA; Mr. Charles S. Nelson, Columbus, Dr. Frank H. Mayfield, Cincinnati, Mr. James Imboden, Columbus, Dr. George W. Petznick, Cleveland, and Dr. Robert S. Martin, Zanesville, representing the Ohio Medical Political Action Committee; Dr. Perry R. Ayres, Columbus, Editor of *The Ohio State Medical Journal*; and Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff. By special invitation the following were present at the meeting on Sunday: Dr. E. W. Arnold, Columbus, Ohio Director of Health; Dr. A. J. Ruppertsberg, Columbus, chairman of the OSMA Committee on Maternal Health.

#### Minutes Approved

Minutes of the following Council meetings were approved by official action: A meeting held on March 27-28; a special telephone conference on April 27; a special meeting held on May 12 at the time of the Annual Meeting at the Sheraton Columbus Hotel; and a special telephone conference held on May 20, 1965. The minutes of these meetings

had been distributed to all members of The Council in advance of the meeting.

#### Membership Statistics

Mr. Page reported on membership statistics as follows: OSMA membership as of July 23, 1965, 9,836, compared to a total membership of 9,720 on July 23, 1964, and 9,933 on December 31, 1964. He reported that of the 9,836 OSMA members, 8,857 were affiliated with the AMA.

#### Reports from Councilors

Reports on the activities in their districts were given by the Councilors.

#### Waiver of Dues for Member In Peace Corps

An inquiry, regarding waiver of dues for a member serving in the Peace Corps, was considered. It was the decision of The Council that such a member is not eligible for waiver of dues under Section 1 (a), Chapter 2 of the Bylaws of the Ohio State Medical Association.

#### Ohio Medical Political Action Committee

Dr. Mayfield discussed plans of the Ohio Medical Political Action Committee and presented a progress report on its activities.

By official action The Council voted to request the inclusion of a billing for membership dues for the Ohio Medical Political Action Committee on the regular county medical society statements beginning in 1966. It was specified by The Council that the Ohio



Medical Political Action Committee reimburse county medical societies for expenses incurred in billing for OMPAC dues. In addition, The Council suggested that the billing procedure be explained at the Fall Councilor District Conferences.

### **New York AMA Meeting**

Dr. Budd reported on the annual meeting of the American Medical Association in New York, June 20-24. The Council accepted the report and congratulated the delegates, alternates, officers and staff for their conduct of the activities in connection with the AMA meeting.

### **1965 Annual Meeting Reviewed**

The Council reviewed the 1965 Annual Meeting held in Columbus, May 9-14.

Mr. George H. Saville expressed thanks and appreciation to The Council and to the Association for the honors and gifts bestowed upon him during this Annual Meeting.

A packet of letters expressing general approbation of the 1965 Annual Meeting was officially received by The Council.

Several resolutions adopted by the Woman's Auxiliary were accepted for information.

### **Resolutions Referred to Committees**

Resolution No. 8, regarding adjustment of dues in financial hardship cases, was referred to the Committee on Auditing and Appropriations for implementation.

Resolution No. 11, regarding proposed amendments to the Ohio Medical Practice Act, was referred to the Committee on Public Relations and Economics.

Resolution No. 20, regarding mental health planning, was referred to the Committee on Mental Health.

### **Plans for 1966 Meeting**

An outline of plans for the 1966 Annual Meeting in Cleveland was presented to The Council. Such outline was approved by official action of The Council, and the chairman of the Committee on Scientific Work was directed to assume carte blanche authority to suggest program content to the affiliated sponsors of the Ohio State Medical Association general sessions and specialty section programs.

### **Dates for Future Annual Meetings**

Dates for future annual meetings of the Association were approved as follows: week of May 14, 1967, Columbus; week of May 12, 1968, Cincinnati; week of May 11, 1969, Columbus; week of May 17, 1970, Cleveland; week of May 9, 1971, Columbus; week of May 7, 1972, Cincinnati.

### **Fall Councilor District Conferences**

It was proposed that the Fall Councilor District Conferences provide a concentration of information and discussion on Federal Government medical pro-

grams and that consultants from the American Medical Association be present to bring information to the county medical society leaders and to receive information from the county medical societies on Federal medical programs already under way. Such proposal was approved by official action of The Council. The staff was directed to proceed to set up the program.

### **Incorporation of Erie County Medical Society**

Proposals from the Erie County Medical Society, involving the incorporation of the society and a change in the constitution and bylaws necessary for such incorporation, were discussed. It was requested that the Erie County Medical Society present the Articles of Incorporation to The Council, along with a code of regulations containing the constitution and bylaws, including the new language necessary under the incorporation procedure.

### **Scioto County Amendments Approved**

The Executive Secretary was instructed to notify the Scioto County Medical Society that The Council approved the amendments to their constitution and bylaws as submitted.

### **Request for Reissuance of Charter**

The Council authorized the issuance of a duplicate copy of the charter of the Lorain County Medical Society upon receipt of an affidavit concerning the existence of the original document chartering the Lorain County Medical Society as a component unit of the Ohio State Medical Association.

### **Meeting of County Society Executive Secretaries**

The Council authorized a meeting of county medical society executive secretaries at the AMA headquarters in Chicago, August 17, just preceding the Medical Society Executive Association Conference and the AMA Public Relations Institute. The Council authorized payment of \$75 toward the expenses of each county executive secretary in Ohio attending the meeting.

### **Maternal Health Matter**

Dr. E. W. Arnold, Ohio Director of Health, appeared before The Council to discuss the problem of integration of "clean gyn patients" on maternity floors in Ohio hospitals. Dr. Arnold suggested that no further action be taken, nor that such a program be implemented, pending results of pilot studies in Chicago, Pittsburgh and New Jersey.

He suggested that those hospitals with low occupancy rates on the obstetric floor should consider structural changes and in some cases a reduction of obstetric beds.

Dr. Anthony J. Ruppertsberg, chairman of the Committee on Maternal Health, pointed out that the existing regulations provide for some leeway in alleviating the problem. It was suggested that hospitals be informed on how they can comply with the

regulations and still utilize the vacant beds on the maternity floors.

### Ohio Medical Indemnity, Inc.

Consideration of an ad hoc committee report on the tenure of office by members of the Ohio Medical Indemnity Board of Directors was held over until the September meeting of The Council.

Presented for the information of The Council was a letter from the Ohio Academy of General Practice, announcing the endorsement by that organization of the new comprehensive Ohio Medical Indemnity insurance contract.

On the question of establishing one income ceiling only, to wit, an income ceiling of \$7,500 in connection with the Ohio Medical Indemnity, Inc. comprehensive contract, The Council deferred action pending receipt of additional information.

Mr. Page announced that the following additional counties have approved the OMI comprehensive contract: Columbiana, Fairfield, Gallia, Morgan, Noble, Van Wert.

Information regarding the practice of Blue Cross and Blue Shield concerning reminder notices of premiums due and grace periods was presented for the information of The Council.

### National Foundation Prenatal Care Project

A communication from the National Foundation — March of Dimes — Ohio state office, with regard to plans of that organization in the area of prenatal care, was discussed by The Council and was referred to the Committee on Maternal Health for study, with instructions for the committee to report back at the September meeting of The Council.

### Consumer Education Program

Information concerning a consumer education program in Scioto County was presented to The Council for information.

### Reports on Meetings

Dr. Howard reported on his visits to the annual meetings of the Ohio Veterinary Medical Association, the Ohio Dietetic Association and the Ohio State Nurses Association, representing Dr. Crawford, President of the Association.

Mr. Saville discussed the Ohio Workshop on Economic Education held on June 30 - July 2 at Athens.

A report on information obtained by Mr. Gillen at a workshop on public health records and statistics was referred to the Committee on Maternal Health for study, with instructions to report at the September meeting of The Council.

Mr. Gillen reported to The Council on a meeting of the Health Education Institute on June 28 - 30.

### The Ohio State Medical Journal

Dr. Perry R. Ayres, Editor of *The Ohio State Medical Journal*, reported on the latest developments with regard to the State Medical Journal Advertising

Bureau. In the opinion of Dr. Ayres, the organization of the Bureau is on the move and growth in advertising revenues to the State Medical Journals can be anticipated.

With regard to the scientific section of *The Ohio State Medical Journal*, Dr. Ayres commented that the role of the scientific section is to (1) inform medically; (2) provide a "sounding board" for Ohio physicians to publish their ideas and to provide a medium for their right to be heard; (3) be a grass roots Journal not competing with national medical journals; (4) encourage physicians to write up case reports since this encourages physicians to think and to study; (5) report medicine as it exists in Ohio.

The Executive Secretary reviewed the role of *The Journal* of the OSMA as a record of history; as a Journal with the proceedings of Association activities, The Council and of the House of Delegates; and as a communications medium to provide emergency medical information and other communications of a similar nature to Ohio physicians.

The Executive Editor of *The Journal* reported on advertising revenues, advising that the reorganized State Medical Journal Advertising Bureau is showing results and that predictions are that advertising will increase.

### Committee on Maternal Health

Mr. Gillen reported for the Committee on Maternal Health. The minutes of the meeting of the committee held on June 14 were approved, including the referral of Dr. Gilbert M. Schiff's project, to investigate the presence of Rubella antibodies in women in Ohio before they become pregnant, to the Committee on Laboratory Medicine for evaluation before final recommendations are developed.

### School Bus Driver Examination

The minutes of the meeting of the Subcommittee on School Bus Driver Examination held on April 2 were accepted as presented by Mr. Gillen.

### Athletics in Elementary Schools

A statement developed by the Advisory Committee on Athletic Injuries dated May 10, 1965, concerning athletics in elementary schools, was approved, with a request that the recommendations in the statement be brought to the attention of educators, parents and the public as rapidly as possible. The recommendations have to do with the establishment of six standards for an acceptable sports program in the elementary schools or in a community recreation program.

### Hospital Relations

The Council approved an Institute on Voluntary Areawide Health Facility Planning to be held in conjunction with the Ohio Hospital Association and the Ohio Osteopathic Association of Physicians and Surgeons.

A communication from the Ohio Hospital Association regarding a coordinating committee for health



facility planning was considered. The Council voted to adopt the recommendations of Dr. William R. Schultz, chairman of the OSMA Hospital Relations Committee, with regard to this matter and that such recommendations be transmitted to the Ohio Hospital Association. Dr. Schultz's recommendations would provide that at least one member of the staff and one Councilor from the Ohio State Medical Association be included under Category B; and that at least one representative from each Councilor District represent medicine in each area of the state under Category C. It was also the decision of The Council to form a committee or to use an existing committee to look into hospital planning and operation in Ohio as these apply to the practicing physicians of the state.

The Council considered the proposed guide for the release of information from medical records. Such guide was approved by the Council, providing the suggested changes by Mr. Wayne E. Stichter, OSMA legal counsel, are incorporated therein.

The Executive Secretary presented a communication from Mr. Walter K. Bailey, Cleveland, President of the Regional Hospital Planning Board of Northeast Ohio, requesting OSMA approval of the board's request for a special project grant in the amount of \$175,000 for the period from December 1, 1965 to June 30, 1968, to supplement an equal amount of local funds for an areawide hospital planning agency. The Council authorized President Crawford to write a letter advising that this matter should be taken up first with the Cleveland Academy of Medicine. It was also suggested that the President call attention to the lack of physician representation on the Regional Hospital Planning Board of Northeast Ohio.

It was announced that the Ohio Hospital Association had scheduled a meeting on the implementation of Medicare for July 29 in Columbus. The Council was advised that a number of physicians attending this session would meet for a conference at 9:15 a. m. in the office of the Ohio State Medical Association.

The Council authorized President Crawford to request each county medical society to appoint a committee on hospital relations and to ask that members of the OSMA Committee on Hospital Relations act as liaison with these county society committees.

#### Committee on Workmen's Compensation

The Council approved the minutes of a meeting of the Committee on Workmen's Compensation held on May 19, 1965.

The Council also approved the usual and customary fee plan for use by the Bureau of Workmen's Compensation.

#### Committee on Mental Health

The Council approved the minutes of the meeting of the Committee on Mental Health held on July 11, 1965. Such approval included the following:

1. The proposed "First Ohio Congress on Psychological Medicine" and the program for the Ohio Congress on Psychological Medicine, to be held in Columbus on October 24.

2. The application for a grant of \$1,000 from the Department of Mental Health of the American Medical Association to cover the speakers' expenses and honoraria in conjunction with the Ohio Congress on Psychological Medicine.

3. The tabling of House of Delegates Resolution No. 20, pending the issuance of the final report of the Citizen's Committee on the Comprehensive Mental Health Planning Project.

4. The support of a continuing program of post-graduate education, including mental health, as a salient feature in the care of patients.

5. A recommendation that the essence of amended House of Delegates Resolution No. 5 be effected by a one-half day program on "community mental health services" at the next county society officers conference was approved with the deletion of the allotment of a specific time for this item on the agenda of the conference.

A section of the minutes dealing with the encouragement and support of career programs for high school and college students in the field of mental health was referred back to the committee for specific recommendations.

The minutes as a whole were then approved as amended.

#### Retirement Committee Dissolved

By official action of The Council the "Retirement Committee" of the Ohio State Medical Association, originally appointed in 1959, was dissolved.

#### Rural Scholarship Winners

Mr. Gillen, reporting for the Scholarship Subcommittee of the Committee on Rural Health, announced the following winners of the 1965 OSMA rural medical scholarships: William J. Brown, Greenville, and George C. Myers, Logan.

#### Centralizing Health Planning Information in Ohio

Mr. Gillen presented material in regard to centralizing health planning information in Ohio. It was requested that copies of the material involving this proposal be sent to all members of The Council and consideration be deferred until the September meeting.

#### V. A. Relative Value Fee Schedule

A letter from Dr. R. K. Laubhan, Cleveland, regarding the Relative Value Fee Schedule of the Veterans Administration Hometown Care Program, was received for information.

#### Osteopaths

The Executive Secretary was instructed to send to Dr. Richard L. Smythe, Mount Vernon, President of

the Knox County Medical Society, material with regard to the OSMA and AMA policies pertaining to osteopathy and material that is available from the American Medical Association with regard to a report to be submitted at the 1965 clinical meeting of the AMA.

### Questionnaire Authorized

The Executive Secretary was authorized to file with Dr. R. C. Derbyshire, Santa Fe, New Mexico, President of the Federation of State Medical Boards of the United States, a completed questionnaire with regard to the problem of the "incompetent physician."

### Laboratory Medicine Conference

With regard to a request from the president of the Ohio Association of Bioanalytical Laboratory Directors for a conference with the OSMA Committee on Laboratory Medicine, The Council advised that such a conference should be optional with the Committee on Laboratory Medicine.

### Dependents' Medical Care Program

Communications concerning the fees for tonsillectomies and for anesthesia fees for tonsillectomies under the Dependents' Medical Care Program were considered by The Council. The Council instructed the Executive Secretary to bring these communications to the attention of the U. S. Department of Defense.

### Miscellaneous Correspondence

A letter from Dr. O. Herman Dreskin, Cincinnati, regarding the OSMA resolution on Medicare was received for information.

A communication from Dr. Bertha M. Joseph, Secretary-Treasurer of the Belmont County Medical Society, with regard to the OSMA action on proposed Ohio constitutional amendment No. 3 was received for information.

### Civil Rights Act "Agreements"

The Council discussed a communication from the Ohio Department of Public Welfare requiring physicians to submit "signed agreements" of compliance with the Civil Rights Act of 1964 before they can be paid for services to welfare patients. The Council requested that the statement of July 16 by the OSMA Director of Public Relations, addressed to Mr. Robert B. Canary, Assistant Director, Ohio Department of Public Welfare, be sent to all Ohio agencies requiring "civil rights agreements."

### Federal Legislation

Mr. Edgar reviewed the latest developments concerning H. R. 3140 and S. 596, legislation to implement regional medical complexes suggested by the DeBakey report, for the information of The Council.

Mr. Edgar then reviewed details concerning the specifications of the Medicare Bill (H. R. 6675), subsequent to the action of the conference committees

of the House and Senate. He announced the effective date of the bill as July 1, 1966.

### State Legislation

The Executive Secretary reviewed the actions of the 106th Ohio General Assembly. He said that a detailed report would be published in a future issue of *The Ohio State Medical Journal*.

The Council approved Senate Bill 62, which would increase the amount of group term insurance available to members of associations and to business executives.

### Ohio Newspaper Association

The Council authorized the Executive Secretary to explore with the Ohio Newspaper Association the problem of the advertising of prescription drugs to the public.

There being no further business, The Council adjourned until the next meeting on September 18 and 19.

Attest: HART F. PAGE  
*Executive Secretary*

## Wholesale Prescription Drug Price Index on Decline

The Wholesale Price Index for Ethical Pharmaceuticals has declined for the sixth straight year.

The index fell during 1964 from a level of 86.2 to an all-time low of 86.0 (1949 equals 100.0). This index, which measures price changes annually, has been prepared by Dr. John M. Firestone, of the City College of the City University of New York.

Dr. Austin Smith, President of the Pharmaceutical Manufacturers Association, said the drop in the index parallels that in the U. S. Bureau of Labor Statistics Wholesale Price Index for "Ethical Pharmaceutical Preparations" since its revision in 1961. The Government Index declined from 100.1 in December 1960, to 94.8 last December, while the industry index declined from 92.4 to 86.0.

Dr. Smith said, "The significance of this index to the public is that wholesale drug price trends are exceedingly favorable when viewed against the price records for all commodities in recent years. While all wholesale prices have risen more than 20 per cent, wholesale drug prices have declined 14 per cent."

### Heart Group Officers Named

All officers of the Northwestern Ohio Heart Association were re-elected at the organization's annual meeting June 3 in the Academy of Medicine Building, Toledo. The officers are Dr. Howard E. Smith, president; Dr. C. Douglass Ford, vice-president; Mrs. A. Lewis Bentley, secretary, and William E. Watson, treasurer. Principal speaker was Dr. Monte Levinson, who is associated with the heart disease control section of the Chicago Board of Health.



## Bill Enacted to Legalize Birth Control Advice

A little-known and never invoked Ohio Statute which has made a lawbreaker of every clergyman, social worker, nurse, attorney or private citizen who recommended birth control to a parishioner, client, patient or friend, has been set aside by the enactment of H. B. 120 by the Ohio Legislature.

"The Comstock Law," enacted almost a century ago, specified a penalty of \$200 - \$2,000 fine and/or one to seven years imprisonment for selling, giving away, lending or advertising information or devices regarding contraception. Under the law repealed, physicians and druggists, "in the course of their normal business," were exempt from these restrictions except that they were prohibited from distributing contraceptives.

This law, its opponents asserted, has seriously hampered the work of family planning organizations and has deprived low income families of desired information, thus resulting in increased public assistance costs.

H. B. 120 removed the references to contraceptive information and devices from the statute, and thus, brings the law into line with current trends.

The measure, supported by The Ohio State Medical Association, was sponsored by Representatives Keith McNamara and Robert E. Holmes of Columbus and Representative Harry V. Jump of Willard. Representative Holmes traced his interest in this subject to the following:

- The much-publicized "population explosion," with low income, low intelligence families, the ones most apt to have the greatest number of children.
- The general policy of state and county welfare agencies not to refer over-breeding couples to Planned Parenthood centers unless requested and the lack of knowledge among the poor that these centers and facilities exist.

- A recent appellate court ruling that the Columbus Planned Parenthood Center, supported by private contributions, had to pay an inheritance tax on a \$5000 bequest. The court held the Center's operation to be "against declared public policy . . . in fact, an agency acting illegally."

While no record can be found of any charge being filed under the birth control information prohibition of the statute, Philip R. Bradley, Columbus attorney who is President of the Planned Parenthood Organization in Franklin County, maintains that the law has limited the organization's effectiveness. Bradley is greatly concerned that, because of the law, persons

who could profit the most from family planning have not been informed of how it can be done.

The bill's sponsors were gratified that there was no organized opposition to the measure during its course through the Legislature. The bill passed the House, 116 to 10, and passed the Senate, 26-3. The new law becomes effective on September 28, 1965.

## M. D.'s in the News

Some 125 persons joined in a reception given in honor of Dr. William M. Champion, Cleveland area pediatrician, who has practiced in the area for some 42 years.

\* \* \*

Dr. George C. Erickson, medical director of Trumbull County's Chronic Illness and Tuberculosis Hospital, was honored as Goodwill Industries' Man of the Year.

\* \* \*

Dr. Robert A. Vogel, Dayton, discussed Medicare at a luncheon meeting of the Jaycees of Greater Dayton.

\* \* \*

Nearly 500 persons attended a dinner at the Hollenden House in tribute to Dr. Bruno Gebhard, who has retired after 25 years as director of the Cleveland Health Museum.

\* \* \*

Dr. Warren G. Harding II, of Worthington and Columbus, will become administrator of Grant Hospital in October when Erwin C. Pohlman, administrator for 26 years, retires.

\* \* \*

Dr. Samuel Kaplan, Cincinnati, was elected president of the Heart Association of Southwestern Ohio. New vice-president is Dr. Virgil D. Hauenstein, also of Cincinnati.

\* \* \*

Dr. Jack L. Kraker, Lancaster, spoke before a meeting of the Wyandot Chapter of the American Business Women's Association, where he discussed medicare.

\* \* \*

Thomas O. Mallory, of Hillsboro, recipient of the OSMA Rural Medical Scholarship in 1961 and for the four years he has been in medical school, received his M. D. degree in June from Ohio State University College of Medicine. His internship is scheduled at Riverside Methodist Hospital in Columbus.

\* \* \*

Six Columbus physicians were appointed to the Medical Advisory Committee of the Central Ohio Diabetes Association — Drs. Robert Magnuson, Joseph Shepard, Walter Baum, Elmer M. Groff, John F. Condon and Paul S. Morton.

# Ohio Fall Postgraduate Programs . . .

## Physicians of This State Have Choice of Many Programs Within Easy Reach of Their Hometowns

**A**N excellent array of postgraduate programs is available to physicians of Ohio for the fall season. Some of these programs are annual events and are well known to doctors of the respective areas. Others are scheduled to serve particular needs.

See also in this issue:

First Ohio Congress on Psychological Medicine, page 842.

Following are District and other programs announced to *The Journal* before this issue went to press.

\* \* \*

### Ohio Surgeons' Cleveland Meeting Scheduled September 24-25

The Tenth Annual Meeting of the Ohio Chapter of the American College of Surgeons will be held in Cleveland, September 24-25, at the Cleveland-Sheraton Hotel.

Dr. John Davis of Cleveland is program chairman for this meeting.

The Friday, September 24, program will feature a panel on the Management of Advanced Pelvic Cancer; Winner presentations of the Resident Essay Contest; Annual Ohio Oration on "Problems of Homotransplantation"; Panel on Management of Hand Injuries; and papers on Present Concepts of Pancreatic Function and Pancreatitis and Theory of Thermal Burns — Recent Advances.

The Saturday morning program will feature subscription breakfast meetings held by the Committees on Surgical Care in the Small Hospital, Dr. W. W. Green of Toledo, Chairman; Post Graduate Surgical Education, Dr. S. O. Hoerr, Cleveland, Chairman; and Trustee-Hospital Administrator-Surgeon Relationship, Dr. Frank Shively, Dayton Chairman. The remainder of the program on Saturday will feature a panel of experts in each of three clinics, Head and Neck; Trauma and Vascular.

Dr. J. P. North of the American College of Surgeons will be a guest and the luncheon speaker on Friday. Officers of the Ohio Chapter include: Dr. Walter A. Hoyt, Jr., Akron, President; Dr. W. W. Green, Toledo, President-Elect; Richard W. Zollinger, M. D., Columbus, Treasurer and Dr. Stephen W. Ondash, 2710 Mahoning Ave., Youngstown, Secretary.

### Neurology Seminar Is Offered At St. Vincent Hospital

St. Vincent Charity Hospital, 2222 Central Avenue, Cleveland, is offering a Neurology Seminar on Wednesday, October 27, beginning at 9:00 a.m. and concluding with a social hour, dinner and an address by an after-dinner speaker. All interested physicians are invited, especially those in the northeastern area of Ohio.

Registration should be made not later than October 15 with the Registrar, St. Vincent Charity Hospital at the foregoing address. Fee for the course, including luncheon, is \$15.00; with an additional \$5.00 for the social hour and dinner.

Master of ceremonies will be Frank R. Hanrahan, M. D., director of medicine for St. Vincent Hospital. After dinner speaker will be Joseph M. Foley, M. D., professor of neurology, Western Reserve University.

The program has been announced as follows:

#### Morning Program

**The Neurology of the Physical Examination**, Simon Horenstein, M. D., Western Reserve University.

**The Neurology of Congenital Heart Disease**, Robert V. McMahon, M. D., St. Vincent Charity Hospital.

**Neurology of Renal Disease**, Thomas W. Wallace, M. D., Cleveland Clinic.

**The Neurology of Hypertension**, William J. Duhigg, M. D., St. Vincent Charity Hospital.

**The Neurology of Pulmonary Disorders**, Fred Plum, M. D., Cornell University.

**The Neurology of Mental Retardation**, Robert Eiben, M. D., Western Reserve University.

**Panel Discussion**, Moderator, John H. Gardner, M. D., Western Reserve University.

#### Afternoon Program

**Physiologic Mechanisms of Disordered Consciousness**, Fred Plum, M. D., Cornell University.

**The Neurology of Virus Disease**, Richard J. Johnson, M. D., Western Reserve University.

**The Neurology of Liver Disease**, Maurice Victor, M. D., Western Reserve University.



## Disaster Hospital Training Program Columbus, October 17

A training program on the operation of Packaged Disaster Hospitals is planned for Sunday, October 17, 1965 at the Arts and Crafts Building and Building 55, Ohio Exposition Grounds, 600 East Seventeenth Avenue, Columbus.

This program will be sponsored by the Ohio State Medical Association Committee on Disaster Medical Care in cooperation with the Health Mobilization Unit, Ohio Department of Health.

The conference is designed to train physicians and others interested in being instructors in the operation of the Packaged Disaster Hospital. The instructors trained in this conference will conduct programs in Cincinnati, Columbus and Cleveland aimed at training a team of persons from each community where a Packaged Disaster Hospital is stored so that they will be able to operate that hospital.

There is no charge for registration. To register, please contact: Mr. W. Michael Traphagan, Secretary, Committee on Disaster Medical Care, Ohio State Medical Association, 79 East State Street, Room 1005, Columbus. The program for the conference is listed below:

### Arts and Crafts Building

- 9:00 - 9:30 a.m. Registration and Welcome  
10:00 Management of Mass Casualties  
10:30 Packaged Disaster Hospital  
11:00 Film "Packaged Disaster Hospital"  
11:30 Utilization of the Packaged Disaster Hospital  
12:00 Lunch

### Building 55

- 1:00 p.m. Functional Section Orientation.  
(Participants will be divided into seven groups and will rotate every 20 minutes through all seven sections.)

1. Admitting and Triage, Thomas W. Morgan, M. D., Gallipolis
2. Ward, N. J. M. Klotz, M. D., Wadsworth
3. Operating, Robert S. Heidt, M. D., Cincinnati
4. Central Supply, Elden C. Weckesser, M. D., Cleveland
5. X-Ray, Thomas D. Allison, M. D., Lima
6. Laboratory and Pharmacy, Nino M. Camardese, M. D., Norwalk
7. Generator and Water Tank, Wendell A. Butcher, M. D., Columbus

### Arts and Crafts Building

- 3:20 Organizing a PDH Training Program  
3:40 Discussion and Adjournment

## Metropolitan Areas and Medical Postgraduate Programs

The accompanying summary of postgraduate programs is presented in an effort to bring together sessions of particular district-wide interest. Many more postgraduate programs are available, particularly in the metropolitan areas. Physicians are invited to contact Academies of Medicine and Specialty Societies in these areas as well as the Medical Teaching Centers for lists of programs scheduled.

## Ohio State University Offers Postgraduate Courses

The Ohio State University College of Medicine has announced a schedule of postgraduate courses for the 1965-1966 season. Following are courses announced for the September-December period.

September 24-25 — Postgraduate Course in Pulmonary Diseases.

October 6 — Tenth Annual Session on Rheumatic Disease.

October 14 — Diabetes Seminar.

October 20 — Pediatric Invitational Seminar (tentative).

October 29-30 — Endocrine Seminar (obstetrics and gynecology).

November 1-24 — Board Refresher Course in Neuropsychiatry.

November 4 — Multiple Sclerosis Clinic Day.

November 7-9 — Medical Education Seminar.

November 24 — Dermatology (tentative).

December 2-3 — Psychiatry Seminar.

Additional courses are pending and may be announced later. Details may be obtained from The Center for Continuing Medical Education, Ohio State University Medical Center, 320 W. Tenth Ave., Columbus 43210.

\* \* \*

## Columbus Academy Announces Specialty Day Program

The Academy of Medicine of Columbus and Franklin County has announced its annual Specialty Day to be held at the Sheraton-Columbus Motor Hotel, Gay and Third Streets in downtown Columbus, to be held on Monday, November 15. Physicians outside of Franklin County who are interested in attending this program are invited to contact the Academy for arrangements. Additional information as to speakers and topics will be announced in a later issue of *The Journal*.

(More Courses on Next Page)

## Course in Diabetes for Physicians Scheduled in Cincinnati

The Diabetes Association of the Cincinnati Area and the University of Cincinnati College of Medicine will offer the Third Post-Graduate Course in Diabetes for Physicians on Thursday, November 18, 8:30 a. m. to 4:45 p. m., at the Carrousel Inn, Cincinnati, Ohio.

Topics to be discussed are the following:

- Development of Insulin Insufficiency
- Present Concepts of Lipid Metabolism
- Significance of Hyperglycemia
- Retinal Pathology Associated with Diabetes
- Non-Ketotic Coma
- Psychological Adjustment in Juvenile Diabetes

Additional information on topics and discussants will be available and may be obtained by writing to the Diabetes Association of the Cincinnati Area, 2400 Reading Road, Cincinnati 45202.

\* \* \*

## Sixth District Postgraduate Day In Canton on October 20

The Sixth Councilor District Postgraduate Day will be held in Canton at the Hotel Onesto on Wednesday, October 20, with registration open at 8:00 a. m. and the program beginning at 9 o'clock. Theme for the program is "What's New in the Practice of Medicine?"

Evening banquet speaker will be Tom Andrews, leading journalist, editorialist, syndicated columnist and worldwide speaker, Dr. A. R. Furnas, 420 Lake Avenue, N. E., Massillon, is Postgraduate Day chairman. Host organization is the Stark County Medical Society, with headquarters at 405 Fourth Street, N. W., Canton.

The program has been announced as follows:

### Morning Program

**Metabolic Aspects of Acute Infections**, Dr. William R. Beisel, Lt. Col. U. S. Army Medical Corps.

**Congenital Orthopedic Anomalies**, Dr. Frederick Rheinlander, associate professor of orthopedics, Western Reserve University.

**Modern Operation of an Industrial Medical Program**, Dr. John MacIver, assistant medical director, U. S. Steel Corporation.

**Radioactive Scanning and Echoencephalography**, Dr. G. Robert Nugent, associate professor of surgery, West Virginia University.

**Laser Surgery and Research**, Dr. K. W. Kitzmiller, Laser Laboratory, Children's Hospital, University of Cincinnati Medical Center.

**Cardio-angiography**, Dr. William C. Sheldon, Department of Pediatric Cardiology, Cleveland Clinic.

Panel: **Threatened Abortion — Its Cause, Man-**

**agement, and Prevention**, Dr. William C. Weir, Dr. Richard Stander, and Dr. William Rigsby.

**Practical Ways to Help the Infertile Patient to Motherhood**, Dr. William Weir, assistant clinical professor, Western Reserve University.

### Afternoon Program

**Medicare — New Aspects and Their Impact on the Practice of Medicine**, Dr. James Donges, Anderson, Indiana.

**Modern Forensic Medicine**, Dr. Lester Adelson, chief of forensic pathology, Western Reserve University.

**A New Look at Viral Immunizations**, Dr. Fred Heggie, Department of Pediatrics, Western Reserve University.

**Recent Advances in Rh Investigation**, Dr. Richard Stander, associate professor of obstetrics and gynecology, Indiana University School of Medicine.

**Induction of Labor — Why, When and How**, Dr. William Rigsby, assistant professor of obstetrics and gynecology, Ohio State University.

**Studies and Experimental Immunopathology**, Dr. Fred Germuth, director of laboratories, Aultman Hospital, Canton.

Panel: **Trauma**, Drs. Rheinlander, Beisel and Nugent.

\* \* \*

## Management of Gynecologic Cancer Symposium at Saint Luke's

Saint Luke's Hospital, Cleveland, Division of Obstetrics & Gynecology, will present a symposium, "Modern Trends in the Management of Gynecologic Cancer," in Saint Luke's Hospital during the afternoon and evening of Monday, November 29.

Two distinguished speakers, Professor H. L. Kottmeier of the Radiumhemmet, Stockholm, Sweden, and Dr. David A. Boyes of the Cytology Institute and British Columbia Cancer Institute, Vancouver, Canada, will present papers, and a distinguished panel of Cleveland gynecologists will take part in a round-table discussion.

Professor Kottmeier is a world-famous authority on radiotherapy and particularly the treatment of cancer of the cervix. Dr. Boyes, a gynecologist and radiotherapist, is a well-known authority on mass cytology screening programs.

Following the afternoon meeting a reception and dinner will be held in Saint Luke's Hospital jointly sponsored by the Cleveland Society of Obstetricians & Gynecologists. Professor Kottmeier will be the featured speaker in the evening.

All interested physicians in the Northeast Ohio area are invited to attend.

Communications may be addressed to: Wendall W. Adams, M. D., Department of Obstetrics, Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland, Ohio 44104.



### Continuing Education Courses Listed by Journal of AMA

An extensive roster of Continuing Education Courses for Physicians throughout the country is printed in *The Journal of the American Medical Association* beginning on page 447 of the August 9 issue.

The list of courses is arranged first according to specialty field, then by states and cities. Many Ohio programs are indicated and physicians will find it to their interest to check those in this state as well as in neighboring areas of surrounding states.

### Gastroenterology, Other Courses Offered by Cleveland Clinic

The Cleveland Clinic is presenting a postgraduate course on Diseases of the Colon and Rectum on Wednesday and Thursday, October 6 and 7. Registration begins at 8:00 a. m. on October 6 with the program beginning at 8:50 a. m.

The faculty consists of local physicians and guest speakers, among them the following:

Robert J. Priest, M. D., physician-in-chief, Department of Gastroenterology, Henry Ford Hospital, Detroit.

Arnold J. Borgen, M. D., medical director, Scott-White Clinic, Temple, Texas.

Richard H. Marshak, M. D., Department of Radiology, The Mount Sinai Hospital, New York City.

Additional information may be obtained by writing Charles H. Brown, M. D., Department of Gastroenterology, Cleveland Clinic, 2020 East 93rd Street, Cleveland, Ohio 44106.

\* \* \*

The Cleveland Clinic Educational Foundation has scheduled a number of postgraduate courses for physicians to be presented by the clinic's staff and guest speakers for the benefit of physicians. Following are courses announced through December:

**Recent Advances in Clinical Pathology**, September 29-30.

**Selected Topics in Hematology**, October 13-14.

**Recent Advances in Medical Treatment**, November 3-4.

Additional courses are scheduled, January to April. Physicians interested in details are invited to write: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland 44106.

Dr. John P. Smith, clinical assistant professor of surgery at Ohio State University, is area chairman of the University of Rochester's \$38 million capital fund campaign.

### Northwestern Ohio Physicians Plan Findlay Program

The Northwestern Ohio Medical Association has announced its annual meeting and scientific program to be held at the Findlay Country Club on Thursday, October 28. The organization consists of physicians of the Third and Fourth Councilor Districts.

A team of physicians from the Cleveland Clinic will present a program dealing with practical gastroenterology. Tentative plans call for a program beginning about 10:00 a. m. Additional information will be published in the October issue of *The Journal*. Arrangements are in charge of Dr. Loren E. Senn, 1400 South Main Street, Findlay.

### Ohio State College of Medicine Announces Professorships

Seven Ohio State University College of Medicine faculty members have been promoted to professorships, Dean Richard L. Meiling has announced.

They are: Dr. Floyd M. Beman and Dr. Robert L. Wall, Department of Medicine; Dr. Dante G. Scarpelli, pathology; Dr. Anthimos J. Christoforidis and Dr. Atis K. Freimanis, both of the Department of Radiology, and Dr. J. Philip Ambuel and Dr. Don M. Hosier, both of pediatrics.

Six clinical professorships were also announced, including: Dr. Wiley L. Forman and Dr. Robert H. Schoene, Department of Medicine; Dr. Robert F. Daly and Dr. Charles W. Pavey, obstetrics and gynecology, and Dr. Philip B. Hardyman and Dr. Richard W. Zollinger, surgery.

Dr. Benjamin Pasamanick, professor of psychiatry at Ohio State University College of Medicine, has been appointed a consultant to the evaluation unit of Project Head Start of the Office of Economic Opportunity.

### New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during July. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

#### Cuyahoga

John E. Colleta, Cleveland  
Fook Lim Dong, Cleveland  
Danilo H. Iglesias, Cleveland  
Howard E. Rowen, Cleveland  
Flory M. Sandoval, Cleveland  
Pradist Satayathum, Cleveland  
Peter H. Tang, Cleveland  
James D. Wismar, Berea

#### Hamilton

Emil John Gritti, Cincinnati  
Sister Joseph Ignatius,  
Cincinnati

#### Montgomery

Michael D. Orlando, Dayton

#### Summit

Lockhart D. Arbuckle, Akron  
Lynn James DeFreest,  
Cuyahoga Falls  
John Charles Johns,  
Cuyahoga Falls  
Robert E. Marsico, Akron  
Alfred L. Nicely, Akron  
Paul N. Pappas, Akron  
Irwin R. Reisberg, Akron  
Thomas R. Riley, Akron

#### Darke

Charles W. Platt, Versailles

#### Franklin

Frank W. Stroebe, Columbus  
Rodolfo S. Vocal, Columbus

# Announcing: First Ohio Congress On Psychological Medicine

Sheraton-Columbus Motor Hotel, Columbus

*Sunday, October 24, 1965*

*Sponsored by*

OHIO STATE MEDICAL ASSOCIATION, COMMITTEE ON MENTAL HEALTH

*Cosponsored by*

Ohio Psychiatric Association

Ohio Chapter, American Academy of Pediatrics

Ohio Academy of General Practice

Ohio Society of Internal Medicine

OSMA Section on Obstetrics and Gynecology

## PROGRAM

### Saturn Room

Presiding: Henry A. Crawford, M. D.

President, Ohio State Medical Association

8:00 - 9:00 A. M. Registration

9:00 Objectives of the Meeting  
Henry A. Crawford, M. D.

Invocation The Rev. Arthur Dimond

9:30 A. M. "The Community Physician"  
William F. Sheeley, M. D.

10:00 - 10:45 A. M. Table Discussion

10:45 A. M. Coffee Break

11:00 A. M. "Depressions"  
Ian Gregory, M. D.

11:30 A. M. Table Discussion

12:15 Luncheon Mars and Jupiter Rooms  
Presiding:  
Wendell A. Butcher, M.D.

### Saturn Room

Presiding: Lawrence C. Meredith, M. D.

President-Elect, Ohio State Medical Association

1:30 P. M. "Mental Retardation"  
George Tarjan, M. D.

2:00 - 2:45 P. M. Table Discussion

2:45 P. M. Coffee Break

3:00 P. M. "Management of Marriage  
Problems"  
Don D. Jackson, M. D.

3:30 P. M. Table Discussion

4:15 P. M. Panel Discussion  
(All Speakers)

5:00 P. M. Adjournment

## ABOUT THE FACULTY

William F. Sheeley, M. D., F. A. P. A., Superintendent, Arizona State Hospital, Phoenix; former director, General Practitioner Education Project, APA; Medical degree, University of Chicago School of Medicine; President, Mid-Atlantic Chapter, American Medical Writers' Association; Member, Educational Advisory Council, National Association for Mental Health; Associate Editor of *Psychosomatics* and *American Practitioner*.

Ian Gregory, M. D., M. P. H., Chairman and Professor, Department of Psychiatry, Ohio State University College of Medicine; Medical degree, University of Cambridge, England; Consultant to U. S. Public Health Service, National Institutes of Health; Author of "Psychiatry: Biological and Social"; and "Abnormal Psychology" with E. Rosen; and over 20 other publications.

George Tarjan, M. D., Superintendent and Medical Director, Pacific State Hospital, Pomona, California; Clinical Professor of Psychiatry, School of Medicine and School of Public Health, University of California at Los Angeles; Medical degree, University of Budapest; Past-president, American Association on Mental Deficiency; Vice-chairman, President's Panel on Mental Retardation (1961-62); Member, Committee on Certification in Child Psychiatry, American Board of Psychiatry and Neurology, Inc.

Don D. Jackson, M. D., Director, Mental Research Institute, Palo Alto, California; formerly Chief of Psychiatry, Palo Alto Medical Clinic; Medical degree, Stanford University School of Medicine; Member, Governor's Advisory Committee on Mental Health (State of California), 1959-1963; recipient of the Frieda Fromm-Reichmann Award, 1961-62, awarded by Academy of Psychoanalysis for significant contribution in the



Program: FIRST OHIO CONGRESS ON PSYCHOLOGICAL MEDICINE  
Place: SHERATON - COLUMBUS MOTOR HOTEL (Saturn Room)  
Time: 9:00 A. M. — OCTOBER 24, 1965  
Fee: \$10.00 PER PERSON (INCLUDES LUNCHEON)

Registrant's Name .....  
(If more than one person, please list others too.)

Address .....

Make Checks payable to:

FIRST OHIO CONGRESS ON PSYCHOLOGICAL MEDICINE

Mail to:

OHIO STATE MEDICAL ASSOCIATION  
79 East State Street, Room 1005  
Columbus, Ohio 43215

#### ABOUT THE FACULTY (*Cont'd.*)

understanding of schizophrenia; author and co-author of over 50 books and publications, among them "Conjoint Family Therapy," *Modern Medicine* May 24, 1965, pp. 172d-198, and "Family Rules — *Marital Quid Pro Quo*" *Arch. Gen. Psychiat.*, Vol. 12, June, 1965.

**The Rev. Arthur Dimond**, Columbus  
Chaplain, Mount Carmel Hospital, Columbus

**Henry A. Crawford**, M. D., Cleveland  
President, Ohio State Medical Association

**Lawrence C. Meredith**, M. D., Elyria  
President-Elect, Ohio State Medical Association

**Wendell A. Butcher**, M. D., Columbus  
Chairman, Ohio State Medical Association,  
Committee on Mental Health

**Purpose:** To present psychiatric subjects of interest to physicians who are not psychiatrists but who face patients' emotional problems in their everyday practice.

**Postgraduate Credit:** This program has been approved for 6 hours of postgraduate credit by the American Academy of General Practice.

**Application Form above:** Should be received by OSMA office by October 15, 1965.

**Accommodations:** Physicians who wish to stay in Columbus over night should arrange their accommodations with the hotel or motel of his choice. The Sheraton-Columbus Motor Hotel is at Gay and Third Streets in downtown Columbus.

#### Body Chemistry Analyzer Used at VA Hospital

At the recent Centennial Symposium of University Hospitals held in Cleveland, Leonard T. Skeggs, Ph. D., chief biochemist for the Veterans Administration in Cleveland, described a body chemistry analyzer now in daily use at the VA Hospital.

Dr. Skeggs reported that the analyzer, from a single sample of blood serum, automatically charts on the patients' medical record measurements of serum calcium, carbon dioxide content, chloride, albumin, alkaline phosphatase, total protein, bilirubin, glucose, sodium, potassium, glutamic-oxaloacetic transaminase, and urea nitrogen.

#### Michigan State Medical Society Plans Centennial Session

The Michigan State Medical Society will celebrate a century of service in medicine at its Centennial Session in Detroit, September 19-24, with headquarters at the Sheraton Cadillac Hotel. Physicians in adjacent states are invited.

Daily themes have been developed and each day will be a convention in itself. For example, Sunday, September 19 will be Medicine and Religion Day; Monday, Medicine and Business, Industry and Communications Day; Tuesday, Medicine and Medical Organization Day; Wednesday, Medicine and Science Day; Thursday, Medicine and Voluntary Health Day; and Friday, Medicine and Government Day.

# Social Security Amendments of 1965...

## H. B. 6675, or Medicare, Has Now Become the Law; Here Is a Resumé of Main Provisions of the Bill

**W**HAT was formerly known as H.R. 6675, or Medicare, is now Public Law 89-97, or "The Social Security Amendments of 1965," having been passed by the House of Representatives and the Senate and signed by the President. Following is a brief analysis of main provisions of the act.

The law has four titles.

Title I is concerned with health insurance for the aged and medical assistance.

Part 1-A of Title I establishes a hospital insurance program patterned after the King-Anderson Bill.

Part 1-B of Title I establishes a voluntary, federally administered medical insurance program to provide benefits which supplement the benefits under the King-Anderson program.

Part 1-C of Title I contains definitions and provisions relating to administration of Parts A and B, and authorizes the Railroad Retirement Board to establish a hospital insurance program identical to that contained in Part 1-A for Railroad Retirement beneficiaries.

Part 2 of Title I establishes a new program which will replace the existing programs for medical assistance under the public assistance programs.

Title II amends the Maternal and Child Health and Crippled Children's programs, extends the grant program for mental retardation planning, amends the public assistance programs to authorize federal participation in assistance to aged individuals with tuberculosis or mental disease, and authorizes appropriations for a study of resources for the diagnosis and prevention of emotional illness in children.

Title III makes numerous amendments to the Old-Age and Survivors Insurance and Disability Insurance programs under the Social Security Act, including compulsory coverage for physicians, payments for nonpermanent disability, and increases in the taxable wage base and tax rate.

Title IV amends the public assistance programs to provide, among other things, increases in the federal contributions for those programs.

### Major Provisions of Bill

**Coverage of Doctors of Medicine:** The law provides for compulsory Social Security coverage for self-employed physicians and for interns and resi-

dents. Coverage and liability for taxes for self-employed physicians are effective for the taxable years ending on and after December 31, 1965.

**Interns and residents** come under compulsory coverage effective January 1, 1966.

**Services of anesthesiologists, pathologists, physicians and radiologists are not covered** under hospital care plan; but are covered under supplementary medical insurance program.

**Basic Hospital Plan** provides 60 days hospital care with \$40 deductible, 30 days additional hospital care, with \$10 a day deductible.

**Post-hospital extended care** (skilled nursing home) provides for 100 days with \$5 deductible after 20th day. Patient must enter nursing home from hospital. Nursing home must have agreement with hospital to participate.

**Post-hospital home health visits:** 100 such visits provided after hospitalization.

**Out-patient diagnostic services** provided on basis of 20 per cent deductible, but may be credited as incurred expense under voluntary medical care plan.

**Psychiatric facilities** are covered, with lifetime limit of 190 days.

**No extended care facility coverage** provided if primarily for care and treatment of mental diseases or tuberculosis.

**Christian Science Sanatoria** services are covered for 60 days with \$40 deductible, plus 30 days with \$10 a day deductible, plus extended care facility coverage for 30 days with \$5 a day deductible.

**Medical and dental interns' and residents' services** covered if under approved training programs.

**Drugs are limited** to certain standard drug formularies, drugs approved by hospital pharmacy and drug therapeutics committees and homeopathic pharmacopæia. Combination drugs are not covered.

**Supplementary medical insurance plan** covers services of physicians and dental surgeons. Podiatry and chiropractic services not included.

**Effective date** of both the health insurance program and the supplementary medical insurance program is July 1, 1966. Some other provisions of the law are effective January 1, 1966 (e.g., the



formula for federal payments to states under certain phases of public assistance programs); other provisions are effective during 1965; and still others (e. g., increased benefits) are retroactive to January 1, 1965.

Medical Assistance programs, including aid for aged, dependent children, etc., were augmented and consolidated.

The legislation places squarely on the shoulders of physicians responsibility for determining eligibility for care and for justifying length of care.

Utilization committees are given major roles in the program. As for terminating hospitalization or care, the Senate Finance Committee reported, "The attending physician would have to be offered an opportunity for consultation before there is a finding . . ."

Secretary of Health, Education and Welfare is given wide latitude in setting rules and regulations for operating the program. Medicine can expect many controversial decrees under this provision.

### Health Insurance Benefits

Under the Health Insurance for the Aged and Medical Assistance program, benefits are authorized for (a) any individual 65 years of age or over who is entitled to monthly insurance benefits under Title II of the Social Security law, whether or not he is receiving them; (b) any individual 65 years of age who is not entitled to benefits under Social Security or Railroad Retirement laws, who attains that age before 1968; and (c) after 1968, anyone who has three quarters of coverage, whenever acquired, under the Social Security or Railroad Retirement laws for each year that elapses after 1965 and before he attains age 65.

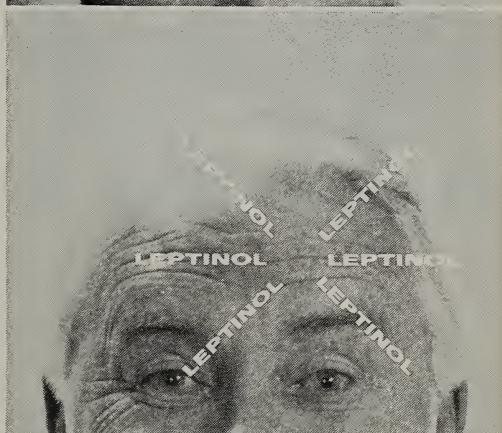
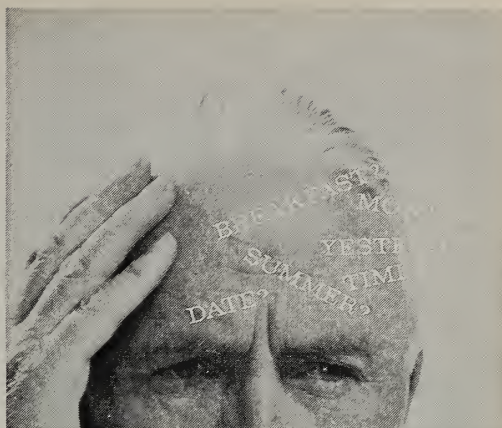
### Supplementary Medical Insurance

Part 1-B of the bill establishes a voluntary insurance program to provide medical insurance for individuals 65 or over who elect to enroll under it. In general it will provide for services of a physician and for dental surgery. This part of the program will be financed from premium payments by the enrollees and by funds appropriated by the federal government.

### Increased Rates

For the information of physicians who deduct Social Security taxes from their employees' wages and pay matching amounts, current rates continue through December 31, 1965. Increased rates begin January 1, 1966, in regard to both the rate and the new wage base.

For the information of self-employed physicians who must satisfy requirements of the new law and pay taxes the current taxable year, as soon as regulations are available, instructions will be issued. Obviously a final reckoning on this tax will have to be made on or before the April 15, 1966 deadline for 1965 federal taxes.



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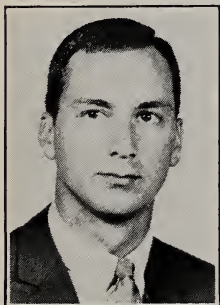
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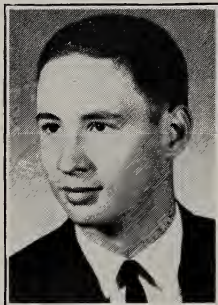
## OSMA Rural Medical Scholarships Are Awarded to Two Students

Winners of the two 1965 Ohio State Medical Association's Rural Medical Scholarships are George C. Myers of Logan, Ohio, and William J. Brown of Greenville, Ohio.

Myers and Brown were selected from a group of 11 students who submitted applications. Each of the winners will receive \$2,000 (\$500 a year) to help meet some of the expenses of medical school.



Wm. J. Brown



Geo. C. Myers

Myers, who did his premedical studies at Muskingum College and at Ohio State University, will enter the College of Medicine of Ohio State University in September.

Brown has been accepted for admission in the College of Medicine of the University of Cincinnati. He completed his premedical studies at the Bowling Green State University.

The Scholarship winners were selected for consistently high ratings for the six categories in which the applicants are judged: character and integrity, native intelligence and mature personality, interest in community activities and organizations, leadership and scholastic ability.

The Rural Medical Scholarships, administered by

the Association's Committee on Rural Health, were initiated 17 years ago to stimulate in young men and women in Ohio's non-metropolitan areas interest in the study of medicine, with the belief that they are more likely to engage in medical practice in rural communities.

This is the second year that scholarships have been awarded to two students. With the beginning of the Fall term, there will be six students in medical school receiving assistance from OSMA. Besides Myers and Brown, past recipients of the scholarship who will be in medical school next year are: Ellen Plummer, Eaton, and Wilbur Neil, Zanesville, (1964 winners); James Haugh, McComb (1963); and Wesley Hiser, Ludlow Falls, 1962.

The OSMA Rural Medical Scholarship Committee functions as a subcommittee of the Committee on Rural Health. Its members are Dr. Luther W. High, Millersburg, Chairman; Dr. Walter A. Campbell, Coshocton; Dr. Jerry L. Hammon, West Milton; Dr. Jasper M. Hedges, Circleville; Dr. Leonard S. Pritchard, Columbiana; and Dr. E. K. Yantes, Wilmington.

## Cincinnati Radiologist Is Honored At Rocky Mountain Meeting

Dr. Benjamin Felson, professor of radiology at the University of Cincinnati, was the subject of a commemorative program August 20 in Denver, Colorado, at the 27th Midsummer Conference of the Rocky Mountain Radiological Society.

Dr. Felson was honored for "signally outstanding" contributions to radiology, according to Dr. Morris H. Levine, of Denver, president of the society.

Nineteen radiologists from all over the nation who trained with Dr. Felson at the University of Cincinnati Medical Center were on the program. Included from Cincinnati, all members of UC's medical faculty, were Drs. Charles M. Barrett, Jerome Wiot, Ethyl Blatt, and Lee Rosenberg. At the banquet that evening Dr. Barrett gave a sketch of Dr. Felson.



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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association

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# NEUROLOGY SEMINAR

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Cleveland, Ohio

Wednesday, October 27, 1965

- 9:00 a. m.    The Neurology of the Physical Examination  
Simon Horenstein, M. D., Western Reserve University
- 9:45         The Neurology of Congenital Heart Disease  
Robert V. McMahon, M. D., St. Vincent Charity Hospital
- 10:10        Neurology of Renal Disease  
Thomas W. Wallace, M. D., Cleveland Clinic
- 10:30        The Neurology of Hypertension  
William J. Duhigg, M. D., St. Vincent Charity Hospital
- 11:00        Coffee
- 11:15        The Neurology of Pulmonary Disorders  
Fred Plum, M. D., Cornell University
- 11:45        The Neurology of Mental Retardation  
Robert Eiben, M. D., Western Reserve University
- 12:30 p. m.   Panel Discussion  
Moderator, John H. Gardner, M. D., Western Reserve University
- 1:00         Luncheon
- 2:00         Physiologic Mechanisms of Disordered Consciousness  
Fred Plum, M. D., Cornell University
- 3:15         Coffee
- 3:30         The Neurology of Virus Disease  
Richard J. Johnson, M. D., Western Reserve University
- 4:30         The Neurology of Liver Disease  
Maurice Victor, M. D., Western Reserve University
- 5:30         Cocktails  
Dinner

*Master of Ceremonies,* Frank R. Hanrahan, M. D.  
Director of Medicine  
St. Vincent Charity Hospital

*Speaker,* Joseph M. Foley, M. D.  
Professor of Neurology  
Western Reserve  
University

*Registration Fee:* \$15.00 Luncheon and Course  
5.00 Cocktails and Dinner

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2222 Central Ave., Cleveland, Ohio 44115

*Reservations must be made by October 15.*

# Woman's Auxiliary Highlights . . .

By MRS. S. L. MELTZER, Portsmouth  
Chairman, Publicity Committee

"SOMETHING OLD, something new . . ." A rather unconventional way, we admit, of paraphrasing a familiar quote to describe the forthcoming Fall Conference to be held in Columbus on September 21 and 22 at Stouffer's University Inn. Yet it is just that — the "something old" in the sense that Fall Conference is an Auxiliary tradition and a tremendously important informative project for local auxiliary officers and chairmen; the "something new" in the sense of its theme — a first — "Problems of Youth and the Family in a Changing World."

Mrs. Herbert Van Epps, state president, and Mrs. James Wychgel, president-elect, have summed it up eloquently: "We feel we must concern ourselves with the increased incidence of crime, the early marriages and all too often resulting high divorce rate, the unwed mothers and fathers, venereal diseases, drop-outs, narcotics, alcoholism, the tragic and needless deaths on the highways and all the other frightening problems that are tending to undermine the stability of the home. Because the doctor and his family are held in high esteem by the community, it becomes the responsibility of the doctor's family to set a good example.

"Only by being fully aware of and educated in the problems of to-day will we be able to solve them. Most young people look to adults for direction and really want it, although they would be the last to admit it. But they do want their parents to love them and believe in them and to hear them say it. Yet there are times when parents must say "No" and must try to make their children understand that much as they do love them deeply and always, they cannot

help but deplore and dislike the inexplicable things they do so often."

The 1965 Fall Conference which is under the competent jurisdiction of the **Summit County Auxiliary** will begin on Tuesday, September 21, with a luncheon at twelve noon (registration and assignment of rooms will be from 10:30 to 11:30 a. m.). Mrs. Paul Sauvageot and Mrs. H. W. Allison are serving as co-chairmen for their auxiliary. The featured speaker is a former F. B. I. man and lawyer, now an Episcopal minister, Reverend William W. Stickle, who will discuss "Youth and the Family" as he sees it. There will be four Tuesday afternoon workshops: Mental Health, Health Careers, Safety, and Publicity.

At 6:15 p. m., a social hour will be hosted by the District Directors. The banquet at 7 o'clock will feature two speakers: Dr. W. Hugh Missildine and Mrs. Frank Gastineau. Dr. Missildine, a Columbus pediatrician and child psychiatrist, will examine "Maintaining Emotional Balance in the Doctor's Family." Mrs. Gastineau, a past National Auxiliary president, and the only woman on the AMPAC Board will bring up-to-date data on AMPAC and OMPAC. Honored guests at the banquet will include Dr. Henry A. Crawford, OSMA President, and Mrs. Crawford; the Auxiliary's OSMA advisors and their wives; and representatives from the OSMA office and their wives.

The Wednesday morning Buffet Breakfast will be hosted by State Board chairmen so that local auxiliaries will have the opportunity to seek out these chairmen and discuss particular problems at that

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time. For the AMA-ERF Workshop from 9 to 10 a. m., and the Organization Workshop from 10 to 11 a. m., the group will be divided according to membership. At 11 a. m., the divided groups will be back together for a Round-Up on Legislation, Community Service and International Health. The 1965 Fall Conference will be officially adjourned at noon on Wednesday, the 22nd. "No special luncheon is planned," explained Mrs. Wychgel. "Each is on her own after that — for shopping, or gadabouting, or just heading homeward."

### "Calling" All Auxiliaries!

The Fall Conference is a must for county presidents, presidents-elect and local chairmen. At no time is more to be made available in the way of practical help than at this September workshop meeting. Yet last year, 23 organized counties had no representation at the Conference. Why should that be so? Certainly the problems attendant upon households and children and other family responsibilities are hardly any different in the small community than in the large. Yet it seems to be the smaller auxiliary which is less likely to send representatives to Fall Conference. Admittedly, the larger Auxiliary has a bigger membership to call upon. Yet we do have good representation from many smaller auxiliaries, so that it seems not so much a matter that it can't be done, but rather that some of the smaller groups lose sight of the real significance of the Conference.

The fact that county programs have already been planned does nothing to alter its importance. For it is here that you learn the practical means of carrying out successfully those projects you have visualized on paper — you'll find out what other auxiliaries are doing and discover that every group has some kind of problem at one time or another. And learn how it was handled successfully.

While the point in setting up the Conference from noon the one day to noon the next is to make it possible for those who come from quite a distance not to have to drive both ways the same day, it serves another useful purpose: By staying overnight, there is more time in which to "fraternize" and to discuss respective problems and ask questions. Of course, if it is quite impossible for the representative of an auxiliary to stay overnight, then she has a choice of attending the sessions of at least one of the two days. After all, half a loaf is still better than none! (But don't forget how much more nourishing is the whole loaf . . .)

### Publicity Chairmen — Please!

Guess if a "plug" should appear anywhere for the Publicity Workshop on Tuesday afternoon, the 21st, it should be right here. Mrs. Paul Sauvageot, editor of the *Auxiliary News*, and your columnist for this Woman's Auxiliary Highlights in the OSMA Journal (Mrs. S. L. Meltzer, in case you don't connect the name with the column) want to help you help yourselves publicitywise. Mrs. H. W. Allison, assistant editor of *Auxiliary News*, will also be on hand to contribute to this Publicity Workshop.

Won't all you county presidents please give the nudge to your local publicity chairman to attend that workshop? We think it will be helpful in ever so many different ways. And while it is fine with us to have the county presidents and presidents-elect come to it too (or any of your other chairmen, for that matter) it is of particular importance that the publicity chairman herself be there. After all, she is the one who is doing the job and something could be lost in the "translation" if someone, other than the publicity gal herself, is getting the message. Every county auxiliary, big or small, needs good publicity — and a good publicity chairman. To help toward that end is the purpose of the workshop at Confer-

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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**Special Notice — State Board**

The Fall Board meeting precedes Fall Conference, as always, by one day — Monday, September 20 at 1:30 p. m., Stouffer's University Inn, of course. There will be a Board reception at 6:15 p. m., followed by a 7 o'clock dinner. On Tuesday morning, the Board will hold a Conference Rehearsal between 10 and 11 a. m. (It always amazes your reporter to note how close to a 100 per cent attendance there usually is on the part of Board members. Such dedication deserves a big hand.)

**A Pair of Apologies**

First — to the Hamilton County Auxiliary for failing to include them in the report given here last month on those in the winners' circle at National Convention. The Hamilton group received an Honorable Mention from the Division of Health Mobilization for an outstanding Disaster Preparedness project — Operation Re-check. In thrashing my way through innumerable notes on the New York story, the notation on the honor Hamilton Auxiliary received was inadvertently overlooked.

Second — to you wonderfully cooperative chairmen who have sent me material for this column and now I can't use it this month! The Fall Conference has had to take precedence. (Don't give up; I'll get it all in yet . . .)

**Famous Last Words**

When? September 21 and 22, noon to noon. What? Fall Conference, State Auxiliary. Where? Stouffer's University Inn, Columbus. Why? To help every county auxiliary, big or small. How? By "grass roots" workshops, friendly discussions and the expert opinions of eminent featured speakers. Which — time? Eastern Standard (this is aimed at you daylight-savers).

The Ohio State University College of Medicine has been awarded a \$46,714 grant from the U. S. Public Health Service for study of human temporal bone pathology. Principal investigator is Dr. William H. Saunders, professor and chairman of the Department of Otolaryngology.

The American College of Physicians has released a listing of its postgraduate programs scheduled from September to June of 1966. Data on programs may be obtained by writing The American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

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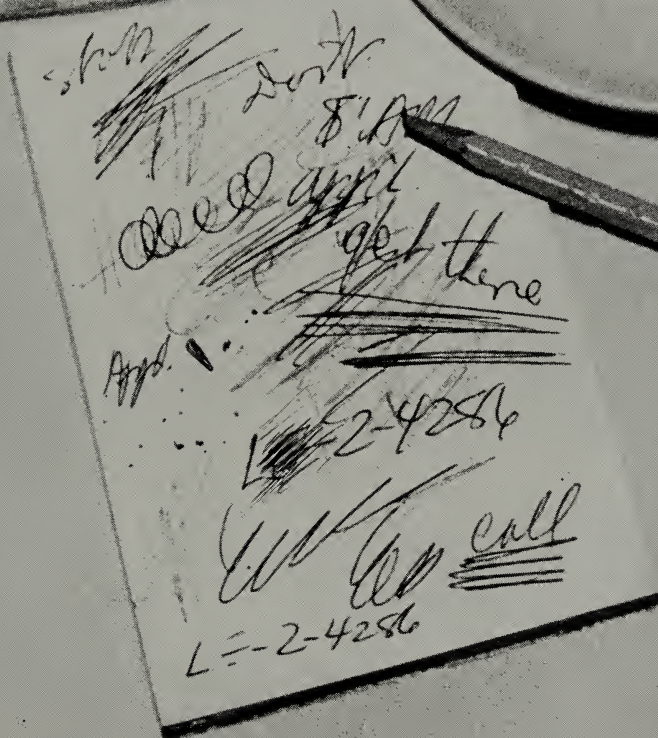
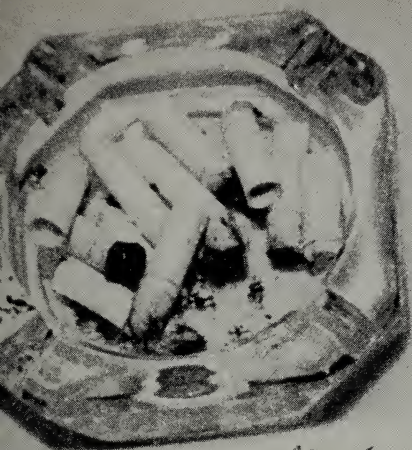
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# Ad Astra

**Beatrice Bamberger, M. D.,** Columbus; University of Maryland School of Medicine, 1931; aged 74; died July 3; member of the Ohio State Medical Association, the American Medical Association and the American Thoracic Society. Dr. Bamberger was living in retirement in Columbus, after serving as staff physician at the Benjamin Franklin Hospital there from 1949 to 1959. She previously practiced in other cities. Among affiliations, she was a member of Temple Israel.

**Carle W. Beane, M. D.,** Eaton; Eclectic Medical College, Cincinnati, 1907; aged 82; died July 9; member of the Ohio State Medical Association and the American Medical Association. A lifelong resident of the area, Dr. Beane practiced in Preble County and in the adjoining area of Indiana. For some years he was Preble County health commissioner. Affiliations included membership in the Lions Club and in the United Church of Christ. Among survivors is a daughter.

**Arthur Curtis Corcoran, M. D.,** Ann Arbor, Mich.; McGill University Faculty of Medicine, 1934; aged 55; died July 3; member of the Ohio State Medical Association, the American Medical Association, Central Society for Clinical Research, American Society for Clinical Investigation, American Psychosomatic Society, Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. Dr. Corcoran died in Czechoslovakia where he was studying advanced cardiac rehabilitation methods as guest of the Czech government. He was in Cleveland from 1945 until his recent move to Michigan, where he was associated with the Veterans Administration. Surviving are his widow, two sons and a daughter.

**Moses Garber, M. D.,** Cleveland; Western Reserve University School of Medicine, 1910; aged 81; died July 2; member of the Ohio State Medical Association and the American Medical Association. Dr. Garber retired in 1961 after more than 50 years of practice in the Cleveland area, where he specialized in obstetrics and gynecology. In 1960 a new maternity facility was established at Mount Sinai Hospital in his name. An honorary life trustee of Park Synagogue, he is survived by his widow and a daughter.

**Thomas Francis Heatley, M. D.,** Toledo; University of Michigan Medical School, 1911; aged 81; died July 2; member of the Ohio State Medical Association and the American Medical Association; Fel-

low of the American College of Surgeons; member of the New York Academy of Science. A practicing physician and surgeon for many years in Toledo, Dr. Heatley was former president of the Toledo Board of Health. Among affiliations, he was a member of the Catholic Church, the Holy Name Society, Knights of Columbus; also a member of the Elks Lodge. Survivors include his widow, three daughters, a brother and two sisters.

**William Walter Sirak, M. D.,** Cleveland; University of Maryland School of Medicine, 1913; aged 73; died July 20; former member of the Ohio State Medical Association and the American Medical Association; member of the American Society of Abdominal Surgeons. A native of Philadelphia, Dr. Sirak practiced for a few years in the East before moving to Cleveland in 1917. He was recently honored for more than 50 years of service in the profession. Surviving are his widow, and a son, Dr. Howard D. Sirak, of Columbus.

**William Henry Strathman, M. D.,** Coral Gables, Florida; Medical College of Ohio, Cincinnati, 1909; aged 78; died July 3; member of the American Medical Association. Dr. Strathman practiced in Toledo from about 1910 to 1933. He was later associated with the Veterans Administration until his retirement in 1957. A son and a sister survive.


## Western Reserve University Grants Again High for the Year

For the second year research grants to Western Reserve University totalled close to \$15,000,000, Allen C. Moore, WRU director of research, reported. Grants for June 1965 reached a total of \$3,841,114 bringing awards for the academic year to \$14,557,629.

Private sources of research grants received during June included the American Cancer Society, American Heart Association, Commonwealth Fund, Heart Association of Northeast Ohio, Muscular Dystrophy Association, National Council of Juvenile Court Judges, National Multiple Sclerosis Society, S. & H. Foundation, Inc., Union Carbide Corp., and the United Fund of St. Marys City.

Government grants were received from the Atomic Energy Commission, U. S. Navy, Office of Education, Public Health Service, Bureau of State Services, Welfare, Interior Department and the National Science Foundation.





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### COMMITTEES

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**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.

**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p. m., monthly, Clinton Memorial Hospital.

**HAMILTON**—Robert M. Woolford, President, 47 E. Hollister St., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

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**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, South West St., Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

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**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.

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**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon. 1st Tuesday, monthly.

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CUYAHOGA—William F. Boukalik, President, 20030 Scottsdale Blvd., Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 6.

GEAUGA—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

LAKE—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

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SUMMIT—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

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JEFFERSON—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

MONROE—Byron Gillespie, Secretary, S. Main St., Woodsfield.

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MORGAN—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

MUSKINGUM—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

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HOCKING—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Brooks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

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PIKE—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.

SCIOTO—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

VINTON—Richard E. Bullock, President, 203 S. Market St., McArthur; David Caul, Secretary, 107 W. Main St., McArthur. Called meetings.

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MORROW—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

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UNION—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

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ERIE—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P. O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

HOLMES—Owen F. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.

HURON—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

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MEDINA—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

RICHLAND—Stanley L. Brody, President, 327 Park Ave W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

WAYNE—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.



## OSMA Issues Policy Statement on Sports for Children in the Elementary Schools

The Ohio State Medical Association - Ohio High School Athletic Association Joint Advisory Committee on Athletics has prepared and OSMA Council has approved recommendations for medical requirements for elementary school and community sports programs for children in grades one through six.

Entitled "Statement on Athletics for Elementary School Age Children (Grades 1-6)," the entire policy statement follows:

Interest in athletics has spread from colleges and high schools to organized sports for pre-adolescent boys and girls in elementary schools (grades 1-6) in the community as well (midget leagues, little leagues, etc.).

There is no doubt that healthy pre-adolescent children require much daily play and exercise and that rigorous physical activity is especially important when many hours are spent in classrooms. Children enjoy competition and will usually find some way to compete, however, if suitable activities are not provided for them, they will play on the sand lot or on the streets.

There are social, psychological, and physiological reasons for developing the best kinds of physical education programs for all children in the schools, supplemented by good, well supervised intramural sports and recreation activities. There is nothing wrong in the enjoyment of sports and games when these activities are supervised and meet reasonable requirements.

### Acceptable Sports Program

An acceptable sports program in the elementary school or in a community recreation program should have the following standards:

(a) Under no condition should such a program replace an activity program for all children in the school or community.

(b) Each child should have had a recent medical examination and authorization to participate. Medical permission to resume participation should be required after significant injury or illness.

(c) Each child should have had tetanus and poliomyelitis immunization before entering a sports program.

(d) Consideration must be given, among pre-adolescent and adolescent children, to grouping or matching children according to size, maturation and strength, to avoid unnecessary injury and to obtain fair competition.

(e) Good playing facilities and equipment are essential.

(f) In the elementary school age children (grades 1-6), interscholastic games should not be scheduled,

for this encourages high pressure, physically and emotionally demanding competition, unsuitable for this age group. For the same reasons there should be no all-star games, "bowl games," and no special scheduling to attract adult spectators.

(g) Tackle football and ice hockey are unsuitable for younger adolescents, because of the problems in matching competitors, the usual lack of suitable protective equipment and typical lack of strength and endurance in these early and pre-adolescent years.

(h) Boxing at any age is not approved by the Ohio Department of Education or the Ohio High School Athletic Association.

## Ohio Psychiatric Association Names Officers for Year

At the recent Annual Meeting of the Ohio Psychiatric Association, held jointly with the Annual Meeting of the Ohio State Medical Association in Columbus, the following officers were elected to serve for the year:

President, W. Donald Ross, M. D., Cincinnati General Hospital, Cincinnati.

Secretary, Philip C. Rond, M. D., 130 South Davis Avenue, Columbus.

Treasurer, Victor Victoroff, M. D., 12200 Fairhill Road, Cleveland.

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## JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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An Ohio medical student, David C. Oehling, of Painesville, will spend several weeks in training at the Evangelical Presbyterian Church Hospital, Adidome Tongu, Ghana, through a fellowship sponsored by Smith Kline & French Laboratories, pharmaceutical firm. A student at the University of Oregon Medical School, Mr. Oehling will be accompanied by his wife. Twenty-eight similar fellowships are being awarded.



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**C I B A**

## Early Influenza Immunization Urged by Committee

The Public Health Services Advisory Committee on Immunization Practices has predicted increased amounts of influenza in the coming season (1965-1966).

The committee again recommended immunization for persons in groups who experience high mortality from epidemic influenza. Vaccination, the committee said, should begin about September 1, and ideally be completed by mid-December.

"It is important that immunization be carried out before influenza occurs in the immediate area since there is a two-week interval before the development of anti-bodies," the committee said.

Groups for which annual immunization were recommended:

"(a) Persons at all ages who suffer from chronic debilitating disease, e. g., chronic and cardiovascular, pulmonary, renal or metabolic disorders: in particular:

"1. Patients with rheumatic heart disease, especially those with mitral stenosis.

"2. Patients with other cardiovascular disorders such as arteriosclerotic heart disease and hypertension, especially those with evidence of frank or incipient cardiac insufficiency.

"3. Patients with chronic bronchopulmonary disease, for example, chronic asthma, chronic bronchitis, bronchiectasis, pulmonary fibrosis, pulmonary emphysema, pulmonary tuberculosis.

"4. Patients with diabetes mellitus and Addison's disease.

"(b) Persons in older age groups.

"(c) Pregnant women.

"(d) Patients residing in Nursing Homes, Chronic Disease Hospitals, and other such environments should be considered as particular risks since their more crowded living arrangements may allow for greater spread of disease once an outbreak has been established."

The committee said that Type A influenza viruses may predominate in 1965-1966 but that Type B outbreaks also could be expected.

As to vaccine efficacy, the committee said:

"Influenza vaccine has consistently shown a substantial protective value when the viruses incorporated in the vaccine were antigenically similar to those causing the epidemic disease. Exceptions to the vaccines' apparent effectiveness have occurred in instances when the prevalent virus underwent a major antigenic shift after vaccines had been formulated. Careful study goes into the annual design and updating of the composition of influenza vaccines. The final selection of components reflects the best judgment regarding a potent, contemporary vaccine . . ."—Reported from the Washington Office of the AMA.

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\*Marks, V., and Dawson, A.: Brit. M. J. 7:293, 1965.

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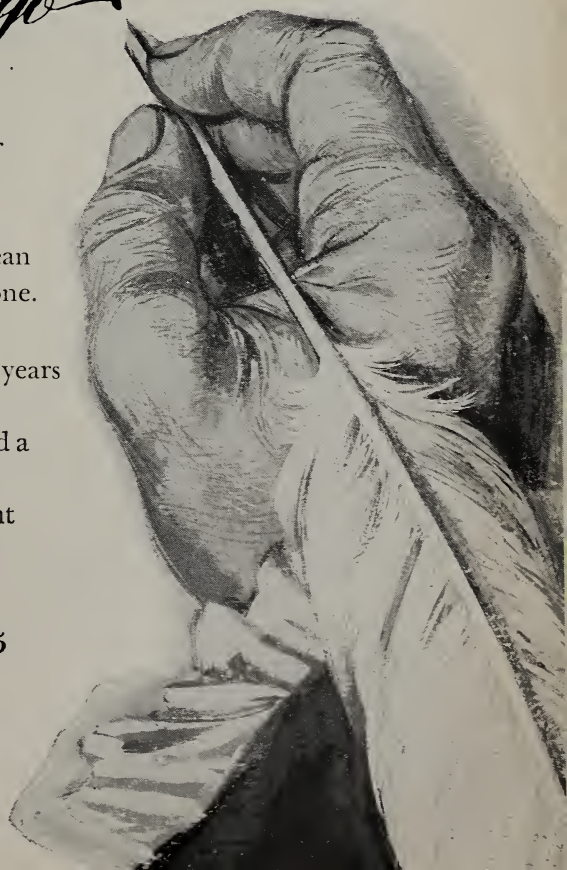
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when President Washington signed the first U.S. patent law. For patents mean drug progress. For example, of the 604 important drugs introduced worldwide since 1941, the majority originated in the U.S. drug industry. By contrast, a major west European nation, which has no patent protection, contributed one.

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## Workmen's Compensation Policy Regarding Certain Patients

Elmer A. Keller, administrator of the Ohio Bureau of Workmen's Compensation, issued the following policy statement in regard to certain patients under the WC program, with the request that it be published in medical and hospital journals:

"All hospitals are cautioned that the use of emergency rooms for after care services such as the redressing of wounds and the application of sterile dressings on outpatients who are sent to the hospital for such service by physicians and are workmen's compensation patients are specifically prohibited by rule 8, of the hospital contract between the hospital and the Bureau of Workmen's Compensation.

"Hospitals rendering such services, unless specifically authorized in writing by the Medical Section of the Bureau of Workmen's Compensation, must look to the attending physician for such remuneration as the hospital usually charges for the use of such facilities and the services rendered.

"Hospital administrators should inform all physicians sending patients to the hospital of such fact."

## OSU Team Studies Human Tolerance To High Altitude Exertion

The U. S. Army Medical Research and Development Command has awarded Ohio State University College of Medicine \$267,000 to study effects of physical conditioning and acclimatization to hypoxia on work tolerance at high altitude.

Two investigators, Charles E. Billings, M. D., and Donald K. Mathews, Ph.D., are directing the project of volunteers in dual settings on the Ohio State campus and at the White Mountain research station of the University of California.

They are working with three groups of eight men to determine what changes, if any, occur in performing tasks at the 12,500 ft., elevation of White Mountain as compared with the 750 ft., elevation of Columbus.

"We have three different conditioning programs underway," Dr. Billings explained. "One group is on a regimen of calisthenics and marching. Another is on the interval-type exercise, which is marked by rest periods followed by maximum effort. Interval conditioning in swimming is well-known. The third group, our control, is assigned only recreational-type exercise—the kind they would normally participate in."

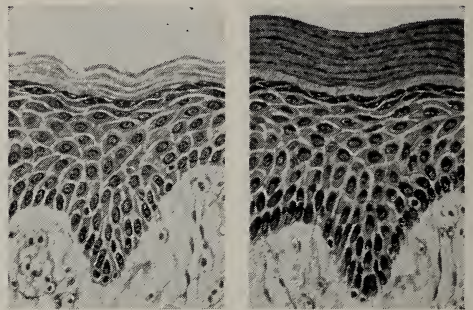
Dr. Billings said there is already a bonus in the project due to the altitude chamber studies at elevation of 7,500 ft. That is the elevation of Mexico City, where the Olympic Games will be held in 1968. Charts have been made of the cardiovascular and metabolic changes on the men in the study at this altitude.

The project is scheduled for completion in December, 1966.



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**References:** (1) Becker, Jr., S. W.: J.A.M.A. 173: 1483-1485, 1960; (2) Pathak, M. A., and Fitzpatrick, T. B.: J. Invest. Dermat. 32:509-518, 1959; (3) Pathak, M. A., Fellman, J. H., and Kaufman, K. D.: 33:165-183, 1960.

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## Physicians Urged to Volunteer For New Viet-Nam Project

In response to an urgent appeal to American Medicine by the President, the American Medical Association is assisting the newly formed voluntary organization known as Project Viet-Nam. This Project, administered by The People-to-People Health Foundation, Inc., is a cooperative medical effort of America's inter-voluntary agencies for the people of South Viet-Nam. The Agency for International Development (AID) is also participating in this program that appears vital to America's success in the present crisis in Asia.

Project Viet-Nam was developed to help alleviate the problem of the critical shortage of physicians in South Viet-Nam—a problem that is crippling and demoralizing the civilian population of the country. The matter is of concern to all physicians—those believing that human life everywhere is sacred, and those sharing a stake in the security of the United States. The American Medical Association, cooperating with the President's request, is appealing to each County and State Society for participation in a program that will assist in the procurement of volunteer physicians for this important venture.

Project Viet-Nam will send teams of 20 physicians into Viet-Nam for periods of just 60 days. The teams will be divided into four groups, each being assigned to a hospital now being operated under the AID program. Facilities and supporting personnel are available at each installation for carrying out services in accordance with acceptable professional standards. While ultimately many disciplines of medicine may be required, the immediate need is for physicians in *general practice, general surgery and orthopedic surgery*. Although service with Project Viet-Nam is on a volunteer basis, transportation from home and return via commercial airline, a nominal per diem, housing, meals and other needs will be supplied. The federal government has also given assurance that all volunteers will be granted the same privileges, courtesies and priority provided government personnel in the area.

Interested physicians may obtain further information and application forms by communicating with: Project Viet-Nam, 2233 Wisconsin Avenue, N. W., Washington, D. C. 20007; Phone: 338-5730 or 338-6110.

## Diabetes and Pregnancy

A symposium on diabetes and pregnancy was held during June in the Charles F. Kettering Memorial Hospital, Kettering. Speakers included Dr. Peter A. Granson, Dayton, chief of staff at Kettering; Dr. Alexander Joseph P. Hoet, Louvain, Belgium; and Dr. Thomas Marble, Boston; Dr. Max Miller, Cleveland; Dr. P. Sharkey, Dayton, moderator.

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Lehmann, H. E., Canad. Psychiat. Assn. J. 4(S): 1-12, 1959

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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# Health Officers of Cincinnati, Ohio And the Problems of Their Day

KENNETH I. E. MACLEOD, M. D., M. P. H.\*

## PART V (Conclusion)

ON THE RISK of spread of infection in barbershops, Dr. Tenny stated that Cincinnati "needed a regulation requiring the sterilization of all tools and toilet articles . . ."

He recommended that the school yards be available to city children during the summer vacation time for playgrounds.

He was interested in improving the environment and the public health — the conditions of the Canal, the problems of nomenclature especially in the filling out of death certificates. On houses of prostitution he wrote: "If a source of disease, they surely should be in the control of the Health Department." He suggested the creation of a special bureau to undertake this work, with the sole duty "to oversee the periodical examination of the inmates . . ."

### Conclusion

As we review the work of the Board of Health, and those several other boards which temporarily or for a period replaced it, and of the too frequently

replaced health officers, in spite of this we note a steady progress both as to the content and the range of the Department's work. It started with the control of nuisances and the attempted control of the more serious communicable diseases primarily through "quarantine," and graduated into a more sophisticated state. The tools of science, particularly the kinds of tests possible in the public health laboratory, lent credence to cause and treatment of communicable diseases. The century has drawn to a close with the signs of a developing school health service, compulsory vaccination, as well as action and demand for an improved water supply, and the control of prostitution among many other items.

We can be proud of these early health officers. Perhaps the one who stands out best as a man of insight and vision, brief although his period of tenure was, is Dr. Thomas Minor. But, none of these health officers, at least by a reading of their words, were less than sound physicians. These were exciting days, and many a physician might well have liked to be at the helm of the good ship, *Public Health*. It is clear that Cincinnati had "skip-pers" to be proud of, and to honor.

\*Dr. Macleod, Cincinnati, is Commissioner of Health, City of Cincinnati.  
Submitted October 4, 1964.

## A D D E N D U M

*An Abbreviated List from the Minutes of Early Boards of Health in Cincinnati, Ohio, for the Protection of Health*

Date	Source	Activity
1802	Session Laws (Act of Incorporation) Ordinance	City Council to make laws and ordinances necessary for the health of the town. Refuse to be buried two feet below ground.
1803		Dog Tax; Registration of Dogs.
1804	Ordinance	Regulations regarding persons having or being exposed to smallpox. In- oculation prohibited.
1811	Ordinance	Stagnant pools ordered filled.
1813	Ordinance	Bills of Mortality a. Every physician and surgeon to leave memo, stating cause of death with head of house. b. Head of house to file said memo with the President or Recorder. c. Clerk to record memo.



Date	Source	Activity
	Proceedings of the Corporation	Nuisances, such as filth, to be removed from cellars, lots, yards as an aid to health.
1815	Session Laws (Act of Incorporation)	Council to make and enforce laws concerning the health of the town.
1815	Minutes of Council	Committees appointed within wards to examine streets for obstructions and nuisances; lots, cellars, and yards for filth and water to report to Marshal. Mayor to ride through streets once a week to observe nuisances to health. Fine for corrupting and befouling walls, cisterns and other public property. (From AN ACT INCORPORATING CINCINNATI AND ORDINANCES 1828, Mayor held Court for trial of following misdemeanors.)
1816	Ordinance	Mayor charged with endorsement of smallpox ordinances authorized to draw on Treasurer for necessary funds.
1818	Minutes of Council	Council allowed doctors their expenses in attendance of smallpox cases.
1819	Ordinance	City Marshal to see that nuisances injurious to health are removed.
1821	Minutes of Council Ordinance	Health Officer appointed to remove nuisances. Resuscitating machinery bought. Health Officer to be appointed. Must be an elector. To have duties of Marshal concerning nuisances and filth, to examine all streets once a week between April and October. Health Officer charged with the duty of picking up stray dogs. Health Officer charged with removing dirt, etc., when scraped from sidewalks and streets by abutting property owners; and to report persons obstructing streets and sidewalks.
1823	Ordinance	Health Officer charged with enforcement of ordinances regarding slaughtering. Health Officer to see that there are no stagnant pools in excavation — must notify owners and convict if not cleaned.
1824	Minutes of Council	Additional health officer elected. Marshal's duty to remove persons with contagious diseases out of the city.
1825	Minutes of Council	Health Department inspects wells.
1826	Minutes of Council Ordinance	Board of Health organized with three members, one an examining physician. Board of Health appointed by Council to remove smallpox patients. Physician appointed by Council to examine for smallpox. Marshal, deputies and Wharf Master made Subordinate to Board of Health. Mayor appointed President of Board of Health. Another member to be appointed by citizens. Health Officer authorized to seal boats left at landing. Personnel of Board of Health changed to three from Council, two from Citizens, President elected by Board, Physician appointed by Board. Marshal, Wharf Master and Health Officer charged with duty of preventing bathing in river in day time.
1827	Minutes of Council Ordinance	City Clerk to list report of deaths weekly to Council and have it published in the Gazette. Duties of Health Officer with respect to streets and sidewalks transferred to Street Commissioners. Personnel of Health Department changes; nine members appointed by Council for three years. President and Secretary elected by Board. Duties, to prevent introduction and spread of disease, and to make recommendations to Council.
1828	Minutes of Council	Board of Health to regulate goods and persons coming from a place infested with smallpox.
1829	Minutes of Council Ordinance	Pest House Established for smallpox. Personnel of Board of Health changed; seven members, Mayor ex-officio given power to establish quarantine.
1832	Minutes of Council	Board of Health established with seven members to enforce sanitary regulations. Board of Health established a temporary cholera hospital. Cases of infectious disease required to be reported to City Clerk. Interments regulated as to size of graves, distance from surface.
1845	Ordinance	Council may provide and care for poor of the city. Vaccination examiners appointed. Vaccination examiners may require vaccination, enforceable by fine.
1845	Ordinance	Board of Health authorized to employ person as clerk, actuary and health officer of Board. Board of Health authorized to publish and enforce bylaws and regulations. Board of Health authorized to require vaccination and to prohibit unvaccinated children from attending school.
	Minutes of Council	Inspector of beef, pork and lard established. House offal to be collected by city from householders after it had been deposited in vessels.

(Continued)

		(Continued)	
Date	Source	Activity	
1849	Minutes of Council Ordinance	Board of Health to consist of one member from each ward. Physicians required to report cases of contagious diseases to Board of Health. City contracted out for collecting of house offal.	
1850	Ordinance	Regulation for interment of the dead. a. Sexton to make weekly reports to City Clerk. b. Clerk to give permits to remove dead bodies out of city. c. Undertakers to make weekly reports.	
	Session Laws	Council to license undertakers.	
1851	Ordinance	Hospital for care of infectious, contagious and malignant diseases established. Board of Health to establish hospital for infectious diseases to receive persons from steamboats.	
1854	Minutes of Council	Inspector of meats appointed.	
1855	Minutes of Council	City Contracts for removal of dead animals.	
1856	Ordinance	Sale of bread regulated.	
1858	Minutes of Council	Board of Health to be composed of four district commissioners for three year terms, four district commissioners for two year terms, and four district members for one year terms. Ordinance to protect consumers of milk and to license number and regulate vehicles used for distribution and sale of milk. Quarantine hospital established. Hospital for care of venereal disease to be established.	
	Minutes of Council	New Commercial Hospital built.	
1860	Session Laws	Hospital Commissioners to provide for rebuilding of hospital.	
1861	Ordinance	Board of Health reorganized.	
	Session Laws	Public infirmary to be known as Commercial Hospital, to be managed by Board of Trustees.	
1863	Minutes of Council	Pest House established under control of Commercial Hospital.	
1866	Minutes	Inspector of meats and fish appointed.	
1867	Ordinance	Inspector of beef cattle, hogs, etc., appointed. Board of Health — six members appointed by Council.	
	Session Laws	Appointment of Health Officer authorized. Clerk, district physicians, sanitary police, free vaccinations, medical relief to poor.	
1868	Ordinance	Bonds issued for completing and furnishing Cincinnati Hospital.	
	Session Laws	Board of Health to have power to make regulations for the public health and for the prevention of disease.	
1872	Session Laws	Board of Health to vaccinate all school children against smallpox.	
1876	Session Laws	Board of Health abolished. Police powers vested in it transferred to Police Commissioners.	
1878	Ordinance	Appropriation of money from Sanitary Fund to establish a quarantine to promote and protect public health.	
1879	Ordinance	To prevent spread of contagious diseases — a. Police Commissioner of Health Officer to have complete charge so far as to restrict access to building where patient is, and communication by inmates. b. Sale or disposition of any clothes, bedding, etc., of patient is prohibited until property is disinfected. c. Captains of vessels must report any case of smallpox found on their boats. Regulations concerning methods to be used by citizens in disposing of garbage, etc.	
1880	Ordinance	Board of Health authorized to be composed of six members appointed by Council.	
1882	Ordinance	Health Department to post notices on houses containing occupants with contagious diseases.	
1883	Ordinance	Construction of cess pools, etc., regulation Board of Health Established. Board of Health regulations a. Diseases and unsound animals not to be sold in markets. b. Slaughtering conditions stipulated. c. Regulations regarding milk.	
1886	Session Laws and Ordinance	Board of Health becomes part of Board of Public Affairs, appointed by Governor.	
1887	Ordinance	Unlawful to expose for sale dressed domestic poultry, unless drawn and entrails removed.	
1888	Ordinance	Provision against sale of adulterated milk.	
1890	Ordinance	Further regulations concerning sale of milk. Provision against throwing refuse in Ohio River within 2,000 feet of Waterworks.	
1892	Ordinance	Contract let for sanitary disposal of garbage.	
1898	Minutes of Council	Bacteriological Laboratory to be established in City Hall.	
1899	Minutes of Council	Separate ward in General Hospital for firemen.	





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# Scientific Section

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## Changes in a Medical Education Program

LLOYD R. EVANS, M.D., and JOHN A. PRIOR, M.D.

THE CURRENTS of change within medical education are as brisk today as they have been at any time since the Flexner Report resulted in a major reorganization of the American medical schools. The etiology of this acceleration lies in the rapid expansion of medical knowledge as well as in a fortunate and growing faculty perception and acknowledgment of the individuality and superior ability of the medical student. The rate of flow of these currents within a given school is determined by the energy and patterns of faculty and administrative action. The course of flow is a direct function of the attitudes of the medical teachers participating in the formulation of any new plans. There must be a substantial intellectual commitment by all concerned if these forces are not to be dissipated and the course lose its direction. Definite educational changes have been accomplished at Ohio State University College of Medicine, over a period of two and one-half years, using a pattern of action described below.

### Methods

The economic realities dictated that the first step in the program was a policy commitment made at the administrative level. In this way, necessary budgetary arrangements could be made. Following this, the initial action was a two day faculty retreat or seminar, held at a facility especially suited for such a meeting, where 50 members of the faculty were accommodated for overnight lodging and meals. An ideally appointed meeting room provided well designed audio-visual aids including microphones which could pick

### *The Authors*

- Dr. Evans, Columbus, Associate Professor in Medicine, is Assistant Dean, The Ohio State University College of Medicine.
- Dr. Prior, Professor in Medicine, is Associate Dean, The Ohio State University College of Medicine.

up talks and discussions for tape recording. This room could seat all the invited faculty and guests for plenary sessions and could be divided into four parts by soundproof partitions for the smaller conferences.

A visiting faculty of five prominent medical educators recruited from the Divisions of Research in Medical Education at the University of Illinois, the University of Southern California and the Association of American Medical Colleges, made presentations to the entire group of 50 and participated in the discussions and conferences. In addition to the participating local faculty, observers were invited from neighboring medical schools and from the American Heart Association, which contributed generously to the partial support of the seminar through an Educational grant-in-aid.

The initial morning and afternoon sessions, which were of a didactic nature, lasted for one hour and 15 minutes. A coffee break followed, after which there were conferences for four small groups lasting an hour and 30 minutes. In these there was a free

give and take of discussion concerning the problems considered. Informal participation continued at meal-times and afterward. On the evening of the first day there was a group dinner followed with a talk by an educator from a nonmedical field. Housing was planned so that a member of a basic science department roomed with a member of one of the clinical departments. This promoted the further consideration of educational, rather than professional topics.

The personnel at this first meeting included all department heads (the Faculty Executive Committee), and substantial representations from the Curriculum and Student Appraisal Committees. Before the retreat, the faculty members who were invited were sent a list of provocative questions concerning the aims and goals of the school, its examination practices, methods of teaching, and faculty and student attitudes. As a result, the transactions were spirited and their influence continued in committee and departmental meetings during the year that followed. One year later a second such retreat was held for 50 faculty members who had not attended the first. Both full-time and part-time teachers participated in the conferences.

The Joint Committee on the Accreditation of Medical Schools of the American Medical Association and Association of American Medical Colleges (A.A.M.C.) made a visitation during the year between the first and second conferences. Its report was available following the second one. Also during the year following the second conference, a medical school self-study was conducted with the assistance of the A.A.M.C. This included comparative statistical material on institutional characteristics, the educational program, a profile of student attitudes, interests and abilities, and the educational output. In addition a questionnaire was circulated to sample classes of Alumni who had graduated at five year intervals concerning their retrospective views of the educational program.

The information from all these studies and comparative data from the A.A.M.C. were used at a third extramural seminar held one year after the second. It was four and one-half days in duration and was held at Sidney, Ohio. The schedule, group size, and visiting faculty resembled those at the previous meetings, and participants received a list of discussion topics for reflection before the meeting. These were the basis of the four days of work. Nearly all the participants had been present at one of the previous conferences and were acquainted with the members of visiting faculty who acted as resource personnel and moderators. There were two important departures from the format of the previous conferences. The first was that once daily the small groups of 12 or 13 broke into subgroups of three or four individuals who were oriented toward a specific problem. The subgroup worked on this and then returned to the group of 12 with a proposal

for its solution which was then discussed and refined. The second was that at the last meeting of the seminar, 17 such proposals were introduced to the group of 50 for consideration. Following this, recommendations were made for further study or implementation by permanent faculty committees or administrators.

## Results

Specific school objectives were defined during the period covered by this program. Some of these were: changes in the current system of grading and class ranking, curricular change to include elective time for students, changes in the departmental structure of the school, modification of the admissions procedures, and the introduction of different methods of teaching and evaluation. There was a need for closer faculty-student relationships, a re-study of faculty teaching time, and a greater availability of student personnel information to teachers.

A need was perceived for the closer integration of basic science and clinical material. Appraisals were to be made of departmental examinations, oral examination procedures and the advisability of certifying examinations. The faculty expressed the desire for the assistance of a professional educator in the educational program. A need was seen for the first year student to have some experiences in the socioeconomic and behavioral aspects of patient care. Other proposals were: the publication of a directory of the particular research interests of faculty members, to promote integrated teaching and research, and the distribution of course outlines to other departments.

Certain of these objectives were achieved following each conference. After the first there was a change from the conventional letter grades, with point averages calculated to the second decimal space, to Honors-Satisfactory-Unsatisfactory grading system with an emphasis on a narrative appraisal of the student's overall performance. Major organizational changes in the college were the establishment of separate departments of Otolaryngology, Ophthalmology, and Pharmacology. The recommendation of the A.A.M.C.-AMA Joint Committee on Accreditation was most helpful in establishing, for the first time, a Division of Medical Microbiology in the College of Medicine as a part of the Department of Pathology. Programmed learning was introduced in some parts of the Anatomy and Biochemistry courses, and two audio-visual self-teaching units were established, one in Anatomy and the other in the clinical subjects. Two methods of teaching Anatomy provided the student with a choice between a conventional didactic course with long required periods of dissection or a conference centered type of teaching with the students taking a more active role, and with less emphasis on the mechanics of dissection.

Further changes were made following the second conference. There was a change in the admissions



procedures which had been centered at the University Admissions Office. Thereafter, the preliminary screening and the locale of the interview were transferred to the College of Medicine, and all applicants were offered a conducted tour of the school. The faculty voted to eliminate 12 courses, with one or two hours of credit, from the curriculum of the first two years. Physiology, which had been taught in the first and second years will be completed in the first, and Microbiology, which had also been divided by the summer, was placed entirely in the second year. Six months of elective time was included in the last two years for elective courses in basic sciences and clinical subjects. These changes were accomplished because of the willingness of departments to give up significant blocks of time, and a reduction in vacation time. There was a trend in student evaluation away from practices based solely on recall to ones which required problem solving.

Although less time has elapsed since the third seminar, a limited number of its objectives have been achieved. There has been a decided increase in integrated teaching in the basic science and clinical years, a well received directory of faculty fields of interest has been published, student personnel files are now being used to gain better knowledge of student capabilities, the Student Appraisal Committee has been decreased to a more effective size, all departments have representation on the Curriculum Committee and some departments are engaging in educational departures like programmed education. Experts in evaluation and instruction from our College of Education have participated in the faculty meetings and are actively engaged in research projects in the Medical School.

### Discussion

The step-wise conduct of these educational endeavors has been very fruitful within the framework of this school. The antecedent two day conferences were necessary so that the faculty could consider and define objectives without interruption of workaday activities. It was during these that individual faculty members developed knowledge in depth about the directions of change in medical education. They recognized the need for more tangible appreciation of student individuality and for eliminating some of his grade engendered tension. Without realization

of these aims, attempts at change would probably have met with lengthy circuitous discussions in the Student Appraisal, Curriculum, and Faculty Executive Committees.

The most important contribution of the first two conferences was to prepare the faculty for more ardent participation in the third, longer A.A.M.C. Intramural Seminar which culminated the year of self-study. In this way the results of the student, faculty, and alumni tests, and the accreditation report could be weighed with greater efficiency and objectivity. It is problematical whether many departments would have been willing to surrender curricular time, had they not first been aware of the long range objectives of such a sacrifice. Certainly, deliberations related to the changes taking place would have occupied a substantially longer time and been associated with the usual uneasiness which accompanies innovation.

Although the visit of the Joint Committee on Accreditation was coincidental it proved to be a fortuitous circumstance. The Committee should give serious consideration to a policy of relating its visits at other schools to similar self-studies and intramural seminars. Such timing would enhance the value of both the inspection and the self-study.

### Conclusion

Substantial educational changes in a medical school require careful preparation and can be accomplished only in a climate of wide faculty participation with wholehearted administrative support. The intramural seminar, employing a staff from elsewhere, is one effective means of achieving such a climate. The participating local personnel should include department chairmen, members of the Curriculum and Student Appraisal Committees and other dedicated faculty of all ranks, full and part-time alike. Individuals of both liberal and conservative educational inclinations must participate and the discussion and reiteration of objectives must continue following conference adjournment.

The concerted use of the intramural seminar, the accreditation inspection and the A.A.M.C. sponsored medical school self-study was a fruitful and even a synergistic combination of events at Ohio State University College of Medicine. Consideration should be given to a policy of combining these activities.

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**T**RAINING OF PHYSICIAN. — The teacher's personality, background and individual philosophy are more important in his relations with patients than whether he is practicing medicine or doing full-time teaching and research. It is certain that each of these groups brings a wealth of talents to the wards and outpatient department of a teaching hospital. A profession so universal in its interests and so demanding in its quest for excellence as medicine needs all the talents that its teachers can muster. — Harry F. Dowling, M.D., and Nicholas J. Cotsonas, Jr., M.D., Chicago: *The New England Journal of Medicine*, 271:716-717, October 1, 1964.

# Coronary Circulation and Myocardial Ischemia

MARTIAL A. DEMANY, M.D., and HENRY A. ZIMMERMAN, M.D.

TO PERFORM its task, the heart must be supplied with enough oxygen and metabolic fuels not only to replace the energy expended as useful work, but also the energy wasted because the heart is not a perfectly efficient pump.

The oxygen content of the coronary venous blood is low at all times; consequently, increased oxygen delivery to the myocardium will depend almost completely on a correspondent increase in coronary blood flow.

Myocardial ischemia occurs when blood flow through the coronary arteries is inadequate to satisfy the oxygen requirements of the myocardium. The coronary blood flow may be insufficient because of increased resistance along the coronary vessels or because of a reduction in the perfusion pressure. In other circumstances, relative coronary insufficiency will result from increased oxygen requirement of the myocardium; in some instances a combination of these factors will be responsible for myocardial ischemia.

Before discussing any further the pathologic physiology of myocardial ischemia, we will outline briefly a few important points in the anatomy of the coronary arteries and the physiology of the coronary circulation.

## 1. Anatomy of the Coronary Vessel

The left coronary artery arises from the left aortic sinus and divides almost immediately into two major branches: the anterior descending artery which gives off several branches to the interventricular septum and the circumflex artery which after coursing around the base of the left ventricle, terminates in a posterior descending branch. The right coronary artery comes off the right aortic sinus, follows the coronary sulcus at the base of the right ventricle to reach the posterior interventricular groove.

The sinus node artery arises from the left coronary artery in about 45 per cent of the cases and from the right coronary artery in the remaining 55 per cent. The sinus node artery always supplies Bachmann's bundle or anterior internodal tract!

Besides these three major trunks a smaller "conus" artery, often arising directly from the aorta, supplies the outflow tract of the right ventricle in about half of the human hearts.

## The Authors

● Dr. Demany, Cleveland, is Assistant in the Marie L. Coakley Cardiovascular Laboratory, St. Vincent Charity Hospital.

● Dr. Zimmerman, Cleveland, is Director of the Marie L. Coakley Cardiovascular Laboratory, St. Vincent Charity Hospital.

Schlesinger<sup>2</sup> has described three general patterns of coronary distribution: (1) right coronary preponderance, found in 48 per cent of a series of postmortem examinations. The posterior portion of the interventricular septum and part of the posterior aspect of the left ventricular wall are supplied by the right coronary artery; (2) left coronary artery preponderance, occurring in 18 per cent of the cases. Practically the whole interventricular septum and the adjacent portion of the right ventricular wall are supplied by the left coronary artery; (3) a balanced coronary distribution was found in about 34 per cent of the cases.

The major arterial trunks course over the external surface of the heart; their muscular branches penetrate the ventricular wall almost perpendicularly and advance toward the endocardium giving off branches to the myocardial fibers. Metarterioles with smooth muscle cells distributed at irregular intervals are found between the arterioles and the true capillaries; they form plain endothelial tubes. Each bundle of myocardial fibers has its individual blood supply, but communicating channels connect these different networks.

The collateral channels connecting the three major coronary arterial systems are usually of small caliber. For Wiggers,<sup>3</sup> these channels are not sufficient to protect the myocardium from the abrupt occlusion of its arterial supply, but the gradual establishment of differential pressures following progressive occlusion of a major arterial trunk may result in the production of a pressure gradient sufficient to distend these collateral channels.

About 60 per cent of the amount of blood entering the coronary arteries comes back through the coronary sinus. Practically all the blood which does

Submitted February 24, 1965.



not return through the coronary sinus, comes back to the right atrium by way of the anterior cardiac veins which lie on the surface of the right ventricle and empty into the right atrium.<sup>4</sup> The left coronary arterial flow returns to the right atrium by way of the coronary sinus, while nearly all the blood entering the right coronary artery re-enters the same chamber through the anterior cardiac veins.

### 2. Physiology of the Coronary Circulation

The flow through the coronary arteries is determined by the pressure gradient between arteries and veins in relation to the total resistance offered in the arteries, capillaries and veins.<sup>5</sup> Some 5 per cent of the total cardiac output in man is allotted to the coronary circulation. This amounts to approximately 250 cc. of blood per minute.

The resistance to flow through the coronary vascular bed varies greatly during the cardiac cycle, especially in the branches located deep between the myocardial bundles; with each systole, these vessels may completely collapse under the external compression of the contracting myocardial fibers. On the other hand,

wall should increase progressively from the intrapleural to the intraventricular pressure level. As one considers successively deeper layers of myocardium, each layer of myocardial fibers contributes equal tension to the development of the systolic intraventricular pressure. Consequently, the terminal arteries, capillaries and veins in the deepest layer of myocardium are submitted to a higher extravascular pressure during systole than the corresponding vessels in a more superficial portion of the myocardium.

Besides this continuous variation in extravascular resistance, the distending pressure within the coronary vessels diminishes as the blood advances through ever-narrowing channels.

The coronary arterial flow drops sharply with the onset of systole as the coronary vessels are compressed by the surrounding contracting myocardial fibers (Fig. 1). Most of the blood contained in these vessels is evacuated through the venous channel accounting for the increased flow from the coronary veins which occurs at the same time as the decrease in arterial flow. Early in systole, there may even be reversal of the arterial flow for a very short period of time. This is followed by a forward surge of flow during midsystole. With the diastolic relaxation of the myocardial fibers, the blood surges into the empty vessels while the outflow from the venous channels decreases markedly.

Because the right intraventricular pressure is much lower, blood flow will continue at a fairly high level during systole in the coronary vessels imbedded within the right ventricular wall since they are submitted to a smaller extravascular compression degree. When the coronary perfusion pressure is increased, there is an augmentation in both the systolic and diastolic flow.

Anoxia results promptly in dilatation of the coronary arterial tree and increase of the coronary blood flow. This can be produced in an animal breathing a mixture low in oxygen even when the elimination of carbon dioxide is normal. High concentration of carbon dioxide will not increase the coronary flow.

Stimulation of the distal end of the severed vagus nerve will not affect coronary flow so long as the heart rate and blood pressure remain unchanged.<sup>6</sup>

Stimulation of the sympathetic nerves to the heart increases the myocardial oxygen consumption. The extraction of oxygen from the coronary bed being practically complete at rest, this increase in oxygen consumption is possible by an increase in coronary blood flow which may result from a reduction in the length of systole, a relative increase in the duration of diastole and from a more vigorous myocardial contraction. An increase in cardiac work always accompanies the increase in coronary flow brought on by sympathetic stimulation.

### 3. Myocardial Ischemia

As we have stated in the introduction to this paper, myocardial ischemia will occur if the coronary flow

### CORONARY FLOW DURING THE CARDIAC CYCLE

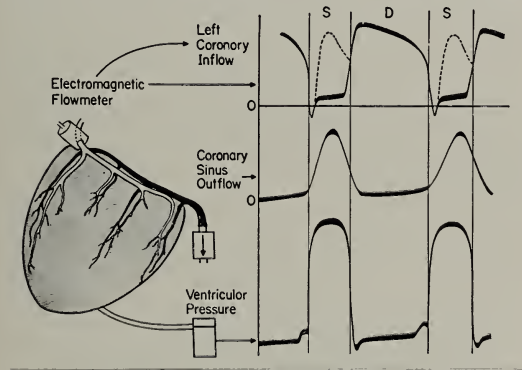


FIG. 1. Continuous measurements of coronary arterial flow to the left ventricle indicate that the inflow to the myocardium is greatly impeded during systole. In fact a retrograde surge from the aorta often appears in early systole. The coronary sinus outflow is accelerated during ventricular systole, indicating that the contracting myocardial fibers wring out the small coronary vessels and veins. Thus, the flow out of the coronary vessels is greatest when the inflow is diminished by the external compressor of the vascular bed within the ventricular walls.

From: Rushmer, R. F.: *Cardiovascular Dynamics*, ed. 2, Philadelphia: W. B. Saunders Co., 1961, p. 217.

during diastole, resistance to coronary flow from external compression will be reduced to a minimum.

The degree of compression of the coronary vessels within the ventricular wall depends upon the pressure attained within the wall during systole.

The large coronary vessels, coursing on the external surface of the heart are submitted to the intrapleural pressure (slightly below that of the atmospheric pressure). The pressure in the subendocardial layer of the myocardium is the reflexion of the intraventricular pressure. The pressure within the ventricular

is inadequate to meet the oxygen requirement of the myocardium. An insufficient coronary flow can be responsible for myocardial ischemia, but on the other hand, relative coronary insufficiency may be due to the increase in the myocardial oxygen requirements; in other instances, both of these factors will play a role in the development of myocardial ischemia.

#### a. Coronary Atherosclerosis

Coronary atherosclerosis is the most common cause of restricted coronary blood flow. It is present in nearly all adults, at least, in the initial stages. White et al.<sup>7</sup> found that the average severity of the lesions increased very rapidly between 30 and 49 years of age. The severity of the lesions was comparable in the main trunk of the right coronary artery and in the anterior descending and circumflex branches of the left coronary artery but the plaques were less extensive in the right marginal and posterior descending branches of the right coronary artery.

Atheromatous plaques reduce the lumen of the coronary arteries, increasing the resistance to blood flow past the site of the lesions. This results in a pressure drop greater than normal beyond each area of obstruction and in the decrease of the perfusion pressure in the terminal arterial branches (Fig. 2). Atheromatous plaques of a given size will have more

dramatic effect on the circulation in the smaller arteries.

Vasodilatation of the small coronary vessels may help compensate for these circulatory disturbances but this is quite limited in extent; consequently, beyond some critical degree, atheromatous plaques will result in a diminished blood flow.

Animal experiments have proven repeatedly the great importance of the rate at which obstruction develops in a coronary artery. In the dog, a major branch of a coronary artery can be gradually occluded over a period of weeks or months, without producing a reduction in ventricular performance or histologic evidence of myocardial damage.<sup>8</sup>

Experimental coronary ligation in the dog, first produces an irregular area of cyanosis in the region supplied by this vessel. Oxygen tension in the muscle decreases rapidly to less than 25 per cent of the baseline values, while in the border areas the diminution in oxygen is not as marked<sup>9</sup> because the collateral circulation, even if not adequate to maintain normal function, is sufficient to preserve viability of these portions of the myocardium.

Within one minute after the obstruction, contractility in the corresponding muscle is so impaired that it stretches during isometric systole, remains stretched during the remainder of systole, and shortens during isometric relaxation.<sup>10</sup> Thus, instead of contributing to systolic ejection, the infarcted area is responsible for an increased volume load to be handled by the remainder of the myocardium. The fibers still actively contracting must release more energy and shorten to a greater extent to compensate for the bulging of the infarcted area.<sup>11</sup> The location and the size of the infarction will determine the extent of this compensation.

Burch and his associates<sup>12</sup> have described mitral insufficiency in patients with an acute myocardial infarction involving the papillary muscle. The infarcted muscle fails to contract during systole and an apical systolic murmur can be heard after the isometric contraction phase of ventricular systole when the corresponding portion of the mitral valve bulges into the left atrium, producing incompetence. Such a complication decreases further the efficiency of the left ventricle. If the remainder of the myocardium and of the coronary vascular tree is in good condition, an adequate compensation will be easier and the chance for survival will be greater.

Despite frequent involvement of the right coronary artery by the atherosclerotic process, isolated infarction of the right ventricle is very rare.<sup>13</sup> This suggests that the blood supply to the right ventricle is great in relation to its workload, which is usually much less than that of the left ventricle.

Coronary spasm can be responsible for increased resistance to blood flow through the coronary arterial tree. Coronary spasm is often thought to be an important factor in causing the attack of angina pectoris

## HYDRAULIC EFFECTS OF VASCULAR OBSTRUCTION

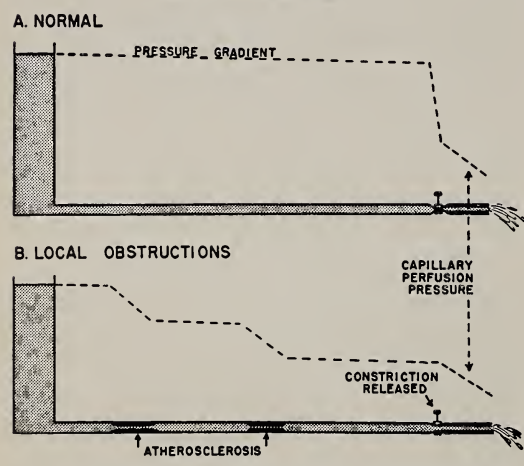


FIG. 2 (A.) Fluid is propelled rapidly through vessels of large caliber by shallow pressure gradients. Pressure declines steeply wherever the caliber is greatly diminished. In the coronary vessels, the pressure gradient steepens as the vessels ramify to smaller and smaller caliber, but the greatest pressure drop occurs at the terminal vessels where peripheral resistance is controlled. (B.) Atherosclerosis produces local obstructions consisting of segments in which the lumen is greatly restricted, as indicated schematically in the drawing. Steep pressure gradients at each restricted segment of vessel may dissipate much of the total pressure head before the blood reaches the terminal branches. Peripheral vasodilatation compensates for the increased resistance upstream, but the reserve coronary flow is depleted in the process.

From: Rushmer, R. F.: *Cardiovascular Dynamics*, ed. 2, Philadelphia: W. B. Saunders Co., 1961, p. 223.



as it can be precipitated by emotional upset, and also because of its short duration. We have seen marked narrowing of the main trunk of the coronary arteries while performing selective coronary arteriography in several patients who were very tense at the time of the procedure. Furthermore, the hypersecretion of epinephrine associated with anxiety will also increase the work of the heart. We believe that severe and prolonged spasm of the coronary arteries occurring in an individual with a coronary blood flow already restricted by atherosclerosis may compromise the delivery of oxygen to the myocardium beyond a critical point and lead to myocardial infarction or to sudden death, by ventricular fibrillation, itself triggered by extreme myocardial anoxia.

*b. Increased Pressure Loads*

Several conditions which impose an increased pressure load on the heart, like systemic hypertension or aortic stenosis, interfere with the delivery of oxygen to the myocardium.

In systemic hypertension, the left ventricle has to work harder to expulse the same amount of blood; this leads to hypertrophy of the myocardial fibers, the result of which is an increased distance between the coronary capillaries and the center of the myocardial fibers (Fig. 3). Besides, systemic hypertension is

often associated with some degree of coronary atherosclerosis, thus increasing the resistance to blood flow and diminishing further the efficiency of oxygen delivery to the myocardial fibers.

In aortic stenosis, the pressure inside the left ventricle may reach very high levels, leading to a more accentuated compression of the arterial branches within the deeper myocardial layers. In the more severe cases blood flow through the coronary arteries may cease during the ventricular systole. Furthermore, hypertrophy of the left ventricle often develops in long-standing cases of aortic stenosis and coronary atherosclerosis can also be present; both make it more difficult to satisfy myocardial oxygen requirements which are increased even at rest.

*c. Increased Volume Loads*

In aortic regurgitation, the quantity of blood ejected by the left ventricle must equal the normal cardiac output plus the volume regurgitating through the aortic valve. This is accomplished by a sustained increase in stroke volume. Thus, the quantity of blood moved by the left ventricle is increased at all times, even at rest. This means that the work of the left ventricle is increased and more oxygen is needed by the myocardium; the coronary flow should then be greater than normal at all times. But on the other hand, the low diastolic pressure in the aortic root

# EFFECTS OF VENTRICULAR DILATATION AND HYPERTROPHY ON CORONARY SUPPLY

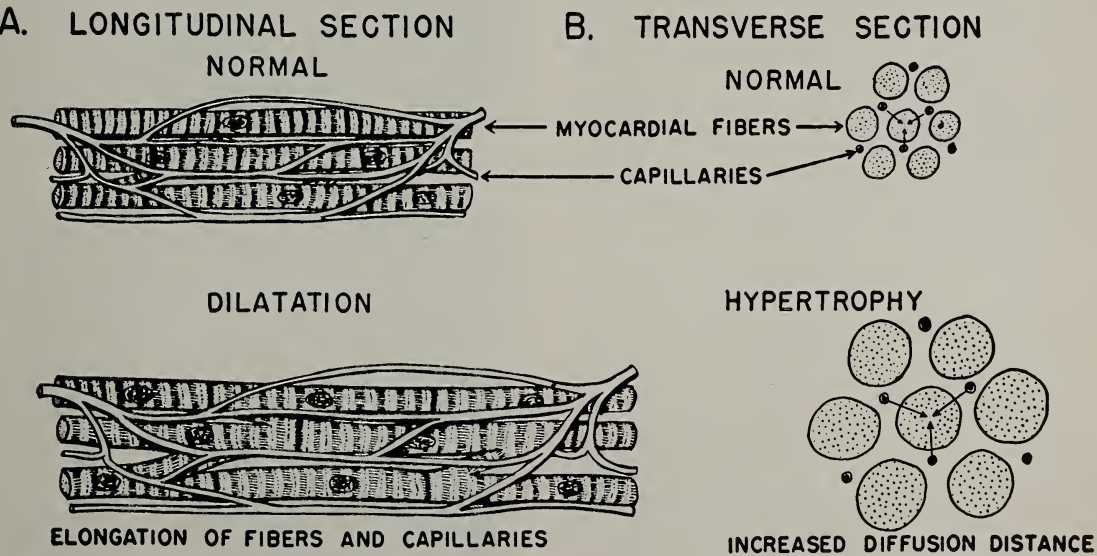


Fig. 3. (A.) Chronic ventricular dilatation involves elongation of both the myocardial fibers and the coronary capillaries. The mass of myocardial contractile units being supplied is greater and the distance traversed by the blood is increased. A greater proportion of oxygen is probably extracted under these conditions. (B.) Ventricular hypertrophy is accomplished by proliferation of contractile units within the individual myocardial fibers. The distance of diffusion from the capillaries to the center of adjacent fibers is increased, retarding the exchange of various substances, particularly oxygen. The diameter of myocardial fibers rarely exceeds 32 per cent even in extreme degrees of hypertrophy.

From: Rushmer, R. F.: *Cardiovascular Dynamics*, ed. 2, Philadelphia: W. B. Saunders Co., 1961, p. 447.

reduces the pressure, forcing the blood through the coronary arteries.

The persistent increase in stroke volume leads to massive dilatation of the left ventricle; this results in the elongation of both the myocardial fibers and the coronary capillaries. The distance travelled by the blood is then increased and each capillary supplies a larger number of myocardial contractile units (Fig. 3).

Selective coronary arteriography often reveals the presence of large coronary arteries with a very rapid flow in patients with marked aortic insufficiency (Fig. 4). Arteriovenous shunts will produce the same pathophysiological disturbances.

#### *d. Myocardial Ischemia in Certain Metabolic Diseases*

Several metabolic diseases are potential causes of myocardial ischemia through reduction of myocardial efficiency, increased myocardial energy release, or both.<sup>12</sup>

Table 1 (from Rushmer<sup>14</sup>) shows the mechanism which can lead to myocardial ischemia in several common metabolic disturbances. In hyperthyroidism, the efficiency of cardiac contraction is diminished by tachycardia and by a direct action of thyroid hormone on the myocardial fibers. At the same time the heart is subjected to an increased volume load to support the increased level of metabolism. When the metabolic rate of a resting patient is 35 per cent above normal, the cardiovascular response is equivalent to that of a normal individual continuously performing moderate exercise, day and night.<sup>15</sup> When such a person performs physical exertion, the circulatory response becomes extravagant; it is then easy to understand that a degree of coronary atherosclerosis mild enough not to cause symptoms in an otherwise normal individual will produce myocardial ischemia on exertion in a hyperthyroid patient.

Patients with gout often develop severe atherosclerosis as well as systemic hypertension, both decreasing the efficiency of oxygen delivery to the myocardium.

Obesity is often accompanied by atherosclerosis and systemic hypertension of a mild or moderate degree; besides, proliferation of capillaries in the newly formed adipose tissue may finally impose an increased volume load on the heart.

Systemic hypertension is a cardinal feature both in Cushing's syndrome and pheochromocytoma. Epinephrine imposes an increased burden on the heart by reducing myocardial efficiency and increasing the cardiac output. Hyperinsulinism can bring on the same changes by provoking the release of excessive amounts of epinephrine. Diabetes mellitus is often associated with severe atherosclerosis and systemic hypertension, usually moderate.

Tachycardia is a prominent feature of beri-beri and is responsible for a reduction in myocardial efficiency along with impaired thiamin metabolism by the car-

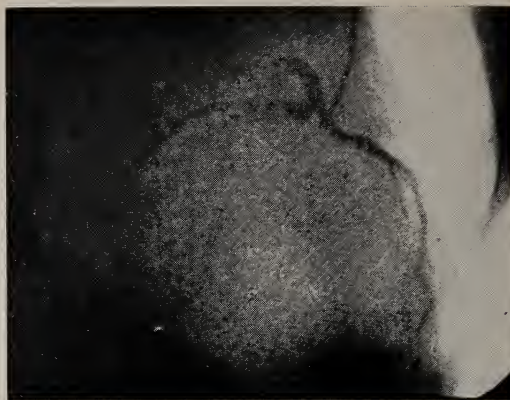


FIG. 4-A. Left coronary artery of a 56 year old patient with massive aortic regurgitation, visualized by hand injection of 5 cc of 60 per cent Methylglucamine Diatrizoate through a No. 7 Sones Coronary Catheter Type I. Right oblique projection using a 9-inch image intensifier, 35 mm. film, 60 frames per second. Note the large size of the main trunk as compared to the catheter.

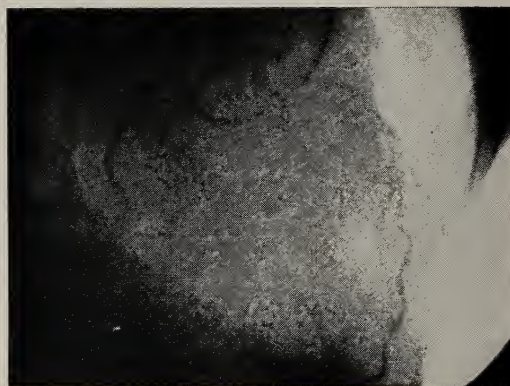


FIG. 4-B Same artery of the same patient as in Fig. 4-A one second later.

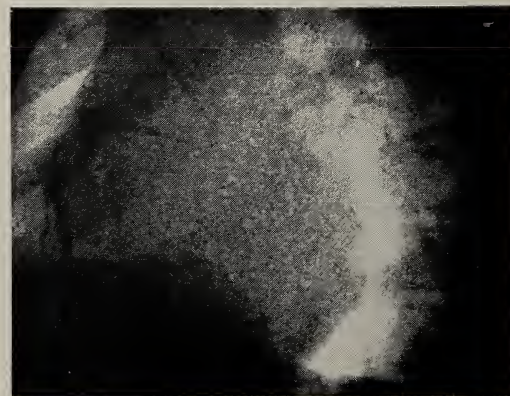


FIG. 4-C. Right coronary artery of a 36 year old patient with marked aortic regurgitation, visualized by the same technique; left oblique projection. Note again the large size of the main trunk as compared to the catheter (Sones No. 7, Type I).



TABLE 1. Causes of Myocardial Ischemia in Metabolic Disease

		CAUSES OF MYOCARDIAL ISCHEMIA			
		RESTRICTED CORONARY FLOW	INCREASED MYOCARDIAL REQUIREMENTS		
			REDUCED MYOCARDIAL EFFICIENCY	INCREASED ENERGY RELEASE	
				HYPERTENSION	INCREASE CARDIAC OUTPUT
1. CORONARY ATHEROSCLEROSIS		X			
2. THYROID DISEASE					
A. HYPOTHYROIDISM	→ ATHEROSCLEROSIS	X			
B. HYPERTHYROIDISM	→ TACHYCARDIA		X		
	→ REDUCED EFFICIENCY		X		
	→ INCREASED BLOOD FLOW				X
3. GOUT	→ ATHEROSCLEROSIS	X			
	→ HYPERTENSION			X	
4. OBESITY	→ ATHEROSCLEROSIS	X			
	→ HYPERTENSION			X	
	→ VOLUME LOAD				X
5. ADRENAL DYSFUNCTION					
A. CORTICAL HYPERFUNCTION (CUSHING SYNDROME)	→ HYPERTENSION			X	
B. MEDULLARY HYPERFUNCTION (PHEOCHROMOCYTOMA)	→ EPINEPHRINE		X	X	
6. HYPERINSULINISM	→ HYPOGLYCEMIA			X	X
	→ EPINEPHRINE		X		
7. DIABETES	→ ATHEROSCLEROSIS	X			X
	→ HYPERTENSION			X	
8. BERIBERI	→ IMPAIRED CONTRACTILITY		X		
	→ TACHYCARDIA		X		
	→ PERIPHERAL VASODILATATION				X

diac muscle. Furthermore, extensive peripheral vasodilatation is responsible for a tremendous increase in cardiac output (values as high as 16.1 liters per minute have been reported).<sup>16</sup> Like in hyperthyroidism, this condition is equivalent to uninterrupted exercise, day and night, for the heart and the final consequence will be identical; myocardial ischemia on effort will develop in the presence of a mild degree of coronary atherosclerosis which would leave an otherwise normal individual asymptomatic.

### Summary

Myocardial ischemia results from the inability of the coronary arteries to supply the cardiac muscle with enough blood to meet its requirements. This may be brought on by an increase in resistance along the coronary vessels, by a reduction in the coronary perfusion pressure, by an increase in the oxygen requirement of the myocardium, or by a combination of these factors.

Coronary atherosclerosis is the most common cause of restricted coronary blood flow. Increased pressure loads (such as in systemic hypertension or in aortic stenosis) and increased volume loads (such as in aortic regurgitation) will interfere with the delivery of oxygen to the cardiac muscle while its amount of work is augmented.

Myocardial ischemia may also occur in certain

metabolic diseases (hyperthyroidism, diabetes mellitus, beri-beri, etc.) because of increased cardiac work, reduced myocardial efficiency, or both.

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# Treatment of Acute Myocardial Infarction

## A Six Month Report of Experience in a Coronary Constant Monitoring Unit

ELISEO S. PANO, M. D., RICHARD W. WATTS, M. D.,  
and MILAGROS C. FLORES, M. D.

**S**UDDEN unexpected death is very common in patients with acute myocardial infarction especially during the first few days of the illness. The mortality from this disease remains disturbingly high in spite of recent advances in its diagnosis and treatment. During the past two years several reports on intensive care units for coronary patients have been published.<sup>1-9</sup> About 45,000 deaths a year could be prevented if all patients with acute myocardial infarction could be provided with constant and intensive care in such units, in order to facilitate early detection of complications and prompt, effective treatment.<sup>1</sup>

We report our experiences during the first six months of operation of one such unit established on one of the medical wards of our hospital.

### The Coronary Constant Monitoring Unit

This unit consists of a four-bed ward served by a nursing station in the same room. The beds can be separated by curtain-partitions, and each patient is attached to and monitored by an oscilloscope and a rate meter provided with an alarm system manufactured by Electronic Medical Specialties, Inc. in Cleveland. The equipment costs less than \$1000 per bed. Both male and female patients are admitted to this room. Nursing duties are done by fully qualified nurses who have been given a series of lectures on electrocardiographic patterns and acute myocardial infarction as well as instruction in resuscitative procedures. One registered nurse and a licensed practical nurse or a well trained nurse's aide care for all four patients on each of the three shifts. However, "back-up" nursing personnel for resuscitative and other supportive needs are made available from the adjoining medical ward. In case of an emergency, immediate help is always available since the unit is equipped with an alarm system. Proper resuscitative equipment and drugs are kept at all times in the unit.

### Admission Procedure

Since the primary purpose of the unit is the constant monitoring of patients with acute symptoms of

### The Authors

- Dr. Pano, Cleveland, is a Cardiovascular Fellow, Department of Medicine, Fairview Park Hospital.
- Dr. Watts, Cleveland, is Chairman of the Cardiovascular Committee, Fairview Park Hospital, and President, Heart Association of Northwestern Ohio.
- Dr. Flores, Cleveland, is a Resident, Department of Medicine, Fairview Park Hospital.

coronary artery disease and because of space limitations, a priority list is used. The following priority applies for admission:

1. Episode of cardiac arrest (standstill or ventricular fibrillation).
2. Episode of ventricular tachycardia.
3. Complete A-V block with Stokes-Adams syncope.
4. Episode of supraventricular tachycardia.
5. Shock.
6. Pulmonary edema.
7. Complete A-V block without Stokes-Adams syncope.
8. Multiple premature beats.
9. Inferior or posterior myocardial infarction.
10. Myocardial infarction in other locations.
11. Acute coronary insufficiency without infarction.

Patients with higher priority displace from the unit those with lesser priority. A record of each admission with information on complications and ultimate outcome is kept in the unit. Detailed records of all patients with acute myocardial infarction whether admitted to the unit or not are kept by the Medical Records Department so that comparisons may be made to determine the value of the unit.

### Materials

All patients admitted from November 1, 1964 to April 30, 1965 with acute symptoms of coronary artery disease were included in this study. Patients with high priority were admitted to the unit while

<sup>1</sup>Submitted May 1, 1965.



patients with lesser priority were not admitted to the unit because of the limited bed capacity.

Results

In the first six months, 107 patients were admitted to the unit. The patients ranged in age from 34 to 88 with a mean age of 61 years. Table 1 shows the type of patients admitted to the unit during this period.

TABLE 1. Type of Patients Admitted

Details	No. of Patients
Total	107
Sex: Male	81
Female	26
Suspected myocardial infarction	95
Proven myocardial infarction	80
Coronary insufficiency	15
Arrhythmias:	
Complete A-V block	5
Second degree A-V block	1
Supraventricular tachycardia	1
Acute pulmonary edema	5

Of the 95 patients with a provisional diagnosis of acute myocardial infarction, the diagnosis was subsequently confirmed on 80. The patients with arrhythmias were admitted because of the availability of the monitoring and pacemaker facilities. Of the six patients with A-V block, five required Goetz electrode catheters and four of these patients required implantable pacemakers. There were 48 patients with substantiated diagnosis of acute myocardial infarction, who were never admitted to the monitoring unit. Table 2 summarizes all the patients with substantiated diagnosis of acute myocardial infarction.

TABLE 2. Patients with Proven Diagnosis of Acute Myocardial Infarction

Details	Admitted to the unit	Not admitted to the unit
Total	80	48
Sex: Male	68	30
Female	12	18
Average age	61	58
Conduction defect only	4	6
Rhythm defect only	29	10
Conduction and rhythm defects	22	1
Shock only	16	4
Congestive heart failure only	11	4
Shock and congestive heart failure	10	3
Predicted to die	32	6
Predicted to die but survived	14	0
Predicted to survive	49	42
Predicted to survive but died	6	4
Deaths	22 (27.5%)	10 (20.6%)
Died in unit	19 (23.4%)	
Died after leaving unit	3	

The incidence of arrhythmias (68.7 per cent or 55 of 80) in patients admitted to the unit was almost double the incidence (35.4 per cent or 17 of 48) in patients not admitted to the unit. Shock and congestive heart failure occurred three times more frequently in patients admitted to the unit than in those not admitted. Consequently, the death rate among patients admitted to the unit was greater than that recorded in patients out of the unit. With the use of discriminant analysis in predicting the outcome of a myocardial infarction as described by Hughes and

associates,<sup>10</sup> the predictive figure of 87.7 per cent for surviving patients in the unit is closely comparable to the predictive accuracy of 97.5 per cent for patients out of the unit. There was a predictive accuracy of 100 per cent for patients who received a "dying score" out of the unit as compared to only 53.3 per cent accuracy for patients admitted to the unit.

The low predictive accuracy of discriminant analysis data on prediction of death of patients in the monitoring unit is the most striking demonstration of the lifesaving function of the unit. Based on the data of Hughes et al.<sup>10</sup> as well as our own experience on the general medical ward, those 14 survivors could well have been fatalities. Thus we recorded a 46.7 per cent reduction in mortality among those patients in the monitoring unit whose predicted outcome was that of fatality. The development of one or any combination of the three main complications of acute myocardial infarction namely shock, arrhythmia, and congestive heart failure was responsible for the low discriminant score obtained in the patients admitted to the unit. Diabetes mellitus was also present in about half of the patients who received a "dying score."

Table 3 shows these complications in relation to

TABLE 3. Complications in Patients Predicted to Die but Who Eventually Survived

Details	No. of Patients
Shock only	3
Arrhythmia and shock	4
Arrhythmia and diabetes	4
Arrhythmia, shock and congestive heart failure	2
Arrhythmia and congestive heart failure	1

the number of patients who were predicted to die but survived.

Table 4 shows the age incidence and the timing of death that occurred in the two groups of patients. In both groups about two thirds of the deaths oc-

TABLE 4. Age Incidence and Time of Death

Details	Patients admitted to the unit	Patients not admitted to the unit
Age: 31 - 40	1	0
41 - 50	5	1
51 - 60	2	1
61 - 70	4	3
71 - 80	9	1
81 - 90	1	1
Time of death		
Within 24 hours	9	1
24 to 72 hours	7	6
After 72 hours	6	3

curred over the age of 60. About 70 per cent of the deaths occurred during the first 72 hours after admission regardless of whether the patients were admitted to the unit or not. In the six deaths that occurred after 72 hours in the group of patients that were admitted to the unit, death occurred suddenly in four patients and was due to far advanced congestive heart failure in two. The four sudden deaths occurred 13 days after admission in two patients and 20 days after ad-

mission in the other two. Three of the six patients who died after 72 hours had been transferred out of the unit at the time of death. Of the three deaths that occurred after 72 hours in the group of patients that were not admitted to the unit, two were attributed to congestive heart failure and uremia, while the third death was attributed to causes entirely unrelated to the myocardial infarction.

The majority of the patients admitted to the unit were monitored for an average time of seven days except for two patients who were monitored more than 15 days—one with far advanced congestive heart failure who stayed for 20 days and the other with repeated episodes of cardiac arrests stayed also for 20 days.

### Comments

The data gathered from our experiences in the first six months of operation of our coronary constant monitoring unit are in agreement with previously published reports.<sup>1-8</sup> It is now widely accepted that abnormalities of rhythm with a reported incidence of 8 to 80 per cent in acute myocardial infarction,<sup>10</sup> not only increase the mortality by causing sudden death, but also initiate or aggravate other complications such as shock and congestive heart failure. However, if arrhythmias and such complications as shock and congestive heart failure are detected and treated early and vigorously, a good number of patients can be saved from predicted fatality. Continuous electrocardiographic monitoring plays an important role in the observation of these patients and affords definite benefits for patients with acute myocardial infarction, especially during the first few days after admission and with very little inconvenience to patients, doctors, and nurses. Of the 80 patients with substantiated diagnosis of acute myocardial infarction, 68.7 per cent (55) developed arrhythmias during the period of monitoring. We believe that more of these patients would have died if monitoring had not detected the onset of the arrhythmias and treatment had not been instituted promptly.

The specially trained nurses, who are at all times in the unit, become highly skilled in recognizing abnormalities of rhythm, such as frequent premature beats and short runs of tachycardias, in order that appropriate drugs can be instituted promptly. The constant presence of the nurses and more frequent visits by the house staff and attending physicians are reassuring to the patient and contribute greatly to his recovery.

About 70 per cent of the patients with proven diagnosis of acute myocardial infarction died during the first 72 hours after admission. The risk was less after this period and, of the 129 cases of acute myocardial infarction admitted to our hospital during this period, only nine died after 72 hours.

While we have had only seven patients who were revived from an episode of cardiac arrest for more than a few hours out of 26 patients in whom resuscitative measures were attempted and while only one

of these seven, a man 65 years old, eventually left the hospital alive, we feel that definite lifesaving value has been shown for the unit in the 14 patients whose predictive score indicated a fatal outcome but who survived, while none of those treated outside the unit with similar predictive scores survived. Our experience thus suggests that constant observation of even the poor risk patient can result in an appreciable reduction in mortality rate but that revival after an episode of cardiac arrest has already occurred is seldom achieved. In general, the most likely patient to be revived from cardiac arrest is the patient with few complications. Since the outcome of myocardial infarction can never be completely predicted as shown by our mortality rates of 12.3 per cent and 2.5 per cent among those predicted to survive in and out of the unit, we strongly recommend that all patients—good risk as well as bad risk—be monitored.

### Conclusions

1. The results of the first six months of a four-bed coronary constant monitoring unit have been presented.

2. A reduction of predicted mortality of 46.7 per cent occurred in patients in the unit whose discriminant analysis score indicated a fatal outcome.

3. Because of the unreliability of survival prediction in myocardial infarction and the greater chance of revival from an episode of cardiac arrest, the "mild" myocardial infarct patient should be provided with constant and intensive care to facilitate early detection of complications and prompt vigorous treatment.

4. Constant monitoring of the coronary patient was performed with equipment costing less than \$1000 per bed and with specially trained nurses.

5. In agreement with other studies, most of the deaths occurred within 72 hours of the myocardial infarct.

6. Because of the lifesaving benefits to be obtained, it is recommended that all hospitals caring for patients with acute myocardial infarction institute coronary constant monitoring units.

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# Hand Infections

F. G. WINEGARNER, M. D., and JAMES E. BENNETT, M. D.

MAJOR hand injuries receive prompt attention and are treated with meticulous technique. Minor injuries are often ignored and frequently become infected.<sup>1</sup> If tendon or bone is involved, permanent disability commonly results. A minor injury, therefore, can be devastating if there is superimposed infection. The number of hand infections seen following insignificant injuries has prompted us to review the cases admitted to our hospital during the eleven year period, 1953 through 1963.

## Clinical Material

During the reporting period 177 patients were hospitalized for treatment of hand infections. Fourteen with paronychia and/or felon were excluded because most patients with similar lesions are treated in the outpatient clinic. Our report, then, is based on the remaining 163 patients.

Infections are classified in Table 1.

TABLE 1

Diagnosis	Number
Cellulitis .....	60
Subcutaneous Abscess .....	42
Tenosynovitis .....	15
Infected Laceration .....	21
Web Space Infection .....	8
Palmar Space Infection .....	5
Infected Ulceration .....	3
Pyarthrosis .....	2
Gangrene .....	3
Osteomyelitis .....	2
Postoperative Infection .....	2
Total .....	163

The majority of infections (two thirds) were classified as cellulitis or subcutaneous abscess. Of the classical compartmental infections,<sup>2</sup> tenosynovitis was the most common, comprising almost 10 per cent of the series. The number of palmar space infections (five), while not great, was still surprisingly high.

Almost 50 per cent of the patients in this series were laborers. Thirty per cent were in their twenties. Seventy-five per cent gave a history of recent trauma to the involved hand. Signs and symptoms of infection usually appeared soon after injury. In more than 60 per cent of the cases, the interval be-

## The Authors

- Dr. Winegarner, Columbus, is Resident in Surgery, The Ohio State University Hospitals.
- Dr. Bennett, Indianapolis, Ind., is Professor of Surgery, and Director, Plastic Surgery Section, Indiana University Medical Center, Indianapolis.

tween trauma and the onset of symptoms was three days or less. Approximately one third of the patients were admitted to the hospital one day after the onset of symptoms, one third two days after, and one third three days after. Thirty-eight patients presented themselves more than three days after the infection was apparent.

## Treatment

All patients with cellulitis were treated with bedrest and elevation of the hand. Some form of moist heat was used in most instances and a systemic antibiotic (usually penicillin) was administered. All patients with localized pus were treated by incision and drainage according to established surgical principles.<sup>1-9</sup> This was necessary in 36 per cent of the patients.

Wound cultures were usually positive. Eighty-three per cent of the positive cultures showed staphylococcus pyogenes, either alone or with a streptococcus. Streptococcus alone was cultured in 11 patients and other organisms accounted for only five positive cultures. The results of the cultures are listed in Table 2.

TABLE 2

Cultures	Number
Staphylococcus .....	67
Streptococcus and Staphylococcus .....	13
Streptococcus .....	11
No growth .....	10
No culture obtained .....	57
Other organism .....	5
Total .....	163

Forty-two per cent of the patients were in the hospital more than five days and 16 per cent more than 10 days. It was not possible from our records to determine loss of work time, but it can be assumed to be about three weeks for the average infection combining the period of hospitalization and of healing with restoration of function.<sup>3</sup> There were three

From the Department of Surgery, Division of Plastic Surgery, The Ohio State University Hospitals and Indiana University Medical Center.

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deaths; two patients with severe diabetes mellitus and complications, and one with gas gangrene and tetanus.

### Discussion

Young laborers are most frequently affected and in at least 75 per cent of cases, a history of trauma was obtained. In the other 25 per cent the trauma was, most likely, too insignificant to recall. Thirty-two per cent of the 10,668 cases reviewed by Leaming<sup>3</sup> were infected and 46.8 per cent of these had a preceding history of trauma. Bingham<sup>4</sup> found that 30.9 per cent of his 15,430 cases were infected and that 75 per cent had had preceding trauma. This emphasizes the need for meticulous care in the treatment of even the so-called minor hand injuries. Morbidity in terms of hospital stay and loss of work time can be considerable. Death may occur with tetanus or gas gangrene and with serious infections in diabetics.

In our series the most common single diagnosis was cellulitis. This infection usually responded to elevation, immobilization of the hand, and moist heat. Providing the patient does not have a known sensitivity or providing the infection was not incurred in a hospital environment, it is well to administer systemic penicillin<sup>1,3-6</sup> for at least seven days for cases of hand cellulitis.

When localized pus is present, incision and drainage must be instituted. On occasion we have deferred incision and drainage for a short time (12 to 24 hours) while treating the patient with rest, elevation, and heat as well as a systemic antibiotic. We feel this procedure has been efficacious, particularly with those patients with a significant amount of cellulitis.

Hand infections are serious in diabetic patients, since two diabetics died. Of these, one had gas gangrene and the other, a beta hemolytic streptococcal infection.

### Summary

Minor hand injuries are frequently overlooked and subsequent infection is common. More careful initial attention to hand injuries should lessen the possibility of infection. In a review of hand infections hospitalized over an eleven year period from 1953 through 1963 we found a significant morbidity and mortality. Most infections occurred in the young laborer who relies on his hands for his livelihood. Forty-two per cent of the patients were hospitalized for over five days and 16 per cent for over 10 days. The loss of time from work was about three weeks. The possibility of permanent damage to the hand as a result of infection is well recognized but follow-up studies were not available for tabulation.

Treatment of hand infections in general is briefly outlined.

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**STUDY OF LIVER DISEASE OF UNCERTAIN ETIOLOGY.**—The cooperation of physicians is requested in a clinical study of liver disease of uncertain etiology being conducted by the Metabolism Service of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Of interest for this study are patients with liver disease of uncertain etiology who would require, in the opinion of the referring physician, a liver biopsy as well as other studies to help establish the specific diagnosis. Those patients with long-standing hyperbilirubinemia or abnormal serum enzyme levels (SGOT, etc.) would be of particular interest.

Patients who are accepted for this study will be admitted to the Clinical Center for approximately two weeks and should anticipate having a liver biopsy performed.

Physicians interested in having their patients considered for the study may write or telephone: Matthew Menken, M.D., Clinical Center, Room 4-N-117, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 656-4000, Ext. 65955 (Area code 301).—ANNOUNCEMENT, Clinical Center, NIH, June 1965.



# Transseptal Orchidopexy

ROBERT YOUNGEN, M. D., and LESTER PERSKY, M. D.

WHEN considering the problem of cryptorchidism in recent years the attention of urologists, pediatricians, and family physicians had been focused largely upon such questions as the appropriate age for surgical correction and the advisability of influencing descent by hormonal administration. Although these areas of debate merit continued discussion and investigation, we have been impressed by a simple technical maneuver which has facilitated the surgical care of this problem, has increased our percentage of good results, and which seems to us worthy of additional emphasis. This has been the employment of a one stage transseptal orchiopexy which has alleviated the necessity for prolonged bed rest, traction sutures, and protracted hospitalization.

This relatively uncomplicated technique was first described by Walter,<sup>1</sup> Gersuy, and Witzel in 1905 and Ombredanne<sup>2</sup> in 1910. Subsequent reports have sporadically appeared in the American literature, the most recent being that of McCormack<sup>3</sup> et al. in 1959. However, the continued use in this country of external traction devices in the majority of cases with the obvious disadvantages of pain and immobilization and the still significant incidence of failures and complications seemed to make worthwhile and even mandatory our review of a very satisfying and satisfactory experience with the one stage transseptal repair of undescended testes.

## Technique

The skin incision employed is usually an inguinal incision which permits ready elongation and more adequate exposure if an extensive retroperitoneal dissection is indicated (Fig. 1). The external oblique muscle is then opened in the course of its fibers down to the external inguinal ring, and the presence or absence of a hernial sac and testes determined. If these structures are located, the standard techniques for elongating the cord and securing adequate lengths are employed. These include dissection of cord structures from off the hernial sac, retroperitoneal dissection with lysis of vascular adhesions and bands, and division of the inferior epigastric vessels where necessary. All of these things are done to permit complete freedom from tension in the final positioning of the testes.

After this is accomplished, the scrotum on the

## The Authors

● Dr. Youngen, Toledo, formerly Chief Resident in Urology, University Hospitals, Cleveland, is now a member of the staff at Toledo Clinic.

● Dr. Persky, Cleveland, is Urologist, University Hospitals, Cleveland, and Professor of Urology, Western Reserve University School of Medicine.

operated side is developed bluntly to permit passage of the testes and cord structures through it (Fig. 2). With one finger in the scrotum exerting pressure to the contralateral sac, a small incision is made through the skin and dartos of this, the opposite scrotal wall. After this incision is made, the septum between the two scrotal halves is opened and the previously mobilized testis is brought into the already prepared subcutaneous pouch (Fig. 3). The septum is then reapproximated with fine chromic catgut sutures which serve to prevent retraction of the newly located testes. The scrotal skin is closed with catgut, and the inguinal incision closed anatomically in lay-

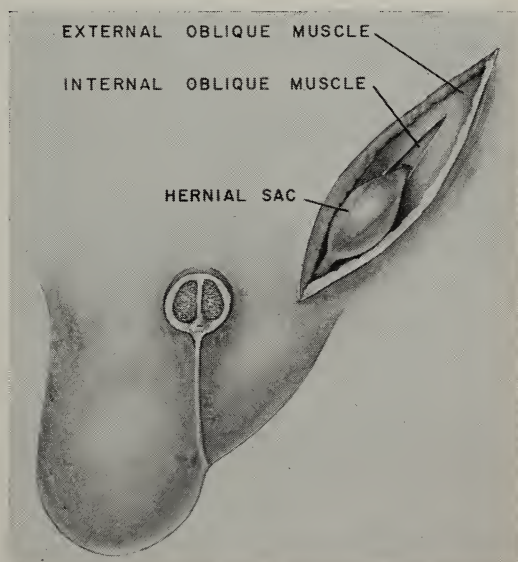


FIG. 1. Figure 1 illustrates the classical inguinal incision with the external oblique fascia divided and the internal oblique and hernia sac exposed.

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ers. Subcuticular stitches of fine nonabsorbable suture material completes the closure and avoids the necessity for later removal of skin silks.

After a period of three weeks the surgically treated cryptorchid is usually located beneath the normal testes. In six to eight weeks after the operation it lies beside its normal mate without tension or distortion. Bilateral undescended testes are treated with separate surgical procedures.

### Experience and Discussion

The hospital records of 30 patients who had 32 orchipexies by the transeptal method in the University Hospitals of Cleveland, Ohio between August, 1962 and August, 1964 were reviewed. The youngest patient was 3 years of age, and the oldest was 23. Six were 6 years or younger, while nine were over 10 years of age.

Fifteen patients had left cryptorchidism only, 13 had right only and, two patients with bilateral cryp-

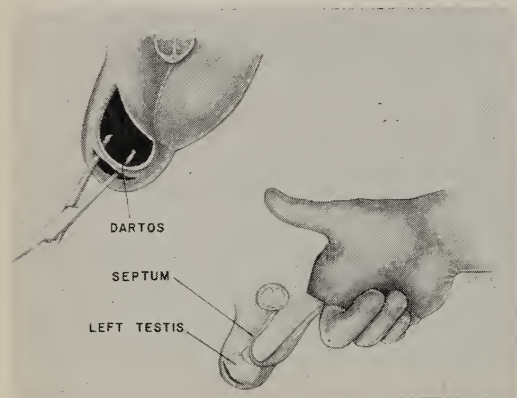


FIG. 2. Figure 2 illustrates the development of the ipsilateral scrotum by blunt dissection and the contralateral scrotal pouch in preparation for testicular placement.

torchidism were treated by separate surgical procedures. None of these patients had prior attempts at orchipexy. In all instances the transeptal orchipexy was employed successfully as far as placement of the testis in the scrotum was concerned. Re-evaluation examination revealed a satisfactory cosmetic result with the testis in the lower scrotum in every instance. Length of current follow-up varies from 4 to 28 months. No follow-up biopsies have been done as yet.

The average hospital stay for the patients was three days. This included one patient who had an incidental orchipexy during repair of an incarcerated hernia and three other patients 16 years or over who had repair of sizable inguinal hernias along with the testicular relocation. As experience with this method has increased, the period of hospital stay has decreased to the point that 13 patients were discharged on the first postoperative day and five on the second day.

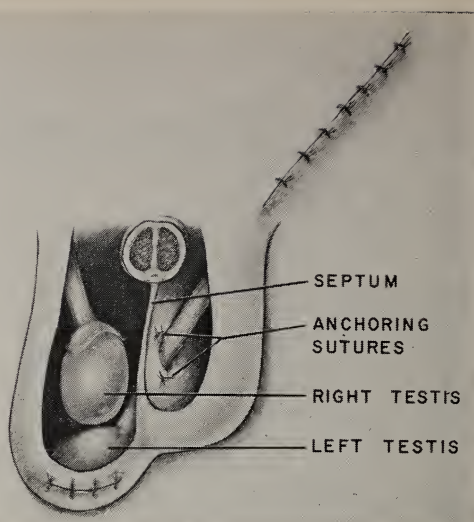


FIG. 3. Figure 3 illustrates the proper placement of the cryptorchid in the contralateral scrotal pouch, the proper closure of the scrotal septum and the relationship of the testicles.

The abbreviated hospital stay made possible by the routine utilization of this repair has many advantages both for the patient and the surgeon. The child is permitted ready mobilization, has no painful traction suture on his thigh, and is quickly returned home to full activity. The ease of carrying out this repair has permitted the surgeon to be optimistic in regard to the likelihood of a brief hospital stay and has rendered the subsequent repair of the contralateral side a less formidable job in terms of ready acceptance on the part of the patient. The elimination of scrotal traction devices or fixation sutures has diminished any attention of the child from the operative site. Usually, the patients are ready for discharge by the afternoon of the first postoperative day. In this era of limited hospital beds, although not of primary consideration, this is an added benefit.

To date, in discussing possible operative results with parents, we have usually mentioned this approach as one of several alternatives. Families are usually delighted with the prospect of early ambulation, early discharge, and early return to full activity. The adoption of the one stage transeptal orchipexy has been of great help, therefore, in minimizing postoperative apprehension, and relieving family anxieties.

### Summary

Thirty-two patients have had 32 orchipexies by the transeptal route. The technique, applicability, and comfort to the patient are emphasized.

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# Melkersson-Rosenthal Syndrome

## Report of a Case

RICHARD D. CARR, M. D.

THE rare association of facial nerve paralysis, facial edema and lingua plicata (scrotal tongue) forms the Melkersson-Rosenthal syndrome. Although Hubschmann in 1894 and Rossolimo in 1901 described cases which probably represented this entity,<sup>1</sup> Melkersson<sup>2</sup> first suggested an association between recurrent seventh nerve paralysis and facial edema in his case reported in 1928. Accordingly, Ekblom<sup>1</sup> gave Melkersson's name to the syndrome in 1942. In 1931 Rosenthal<sup>3</sup> first noted the coincidence of plicated or scrotal tongue with the facial paralysis and swelling. Although occasional mention has been made of the occurrence of some part of this symptom-complex in relatives of reported cases, no suggestion can be found in the pertinent literature that heredity might be a causative factor in this disease process of unknown etiology.

### Report of Case

A 19 year old white man was first seen in September, 1963 for treatment of a small verruca vulgaris on his left little finger. During the interview, right facial paresis and rather marked swelling of the right side of the lower lip were noted. History given by the patient and corroborated by his mother disclosed that there was a sudden onset of right facial weakness preceded by a severe headache when the patient was five years old. His physician made a diagnosis of "possible polio with Bell's palsy" at that time. The facial paralysis has improved slowly over the years. There has been a gradual asymptomatic increase in the size of the lower lip, especially on the right side, since shortly after the onset of the facial palsy. No notable exacerbations or remissions in either process have occurred during the intervening years. About one year after onset of the palsy, at age six, the patient was found to have diabetes mellitus which has persisted, requiring daily insulin injections and dietary control. His general health has been good otherwise.

A review of his family history revealed that his mother and maternal grandmother have lingua plicata. This was confirmed by personal examination of both of them by the author (Figs. 4 and 5). There was no family history of facial weakness or swelling. The maternal grandfather had "mild" diabetes mellitus.

Physical examination of the patient revealed a well-developed, well-nourished, young man with a rather profound, peripheral type of right facial (Bell's) paresis (Fig. 1). The lower lip was swollen, especially on the right side, to twice its normal size (Fig. 2). The swelling was moderately soft, non-pitting and non-tender. There were mild dryness, fissuring, and scaling of the involved lip surface. The tongue was unremarkable (Fig. 3). Hematoxylin and eosin stained histologic sections from a punch biopsy of the right side of the lower lip revealed moderate

### The Author

● Dr. Carr, Columbus, is a member of the Attending Staffs, The Ohio State University Hospital, and Children's Hospital; Assistant Professor, Department of Medicine (Division of Dermatology), The Ohio State University College of Medicine.

lymphangiectasis with mild focal and scattered lymphocytic infiltration throughout the dermis. No epitheloid cells, giant cells, or granulomatous reaction were seen. Roentgenograms of the right mastoid area of the skull and of the chest were unremarkable. Chromosomal analysis of the patient's blood cells revealed "normal male karyotype."

### Comment

In commenting on the frequent appearance of the formes frustes of the Melkersson-Rosenthal syndrome, Klaus and Brunsting<sup>4</sup> have suggested that,

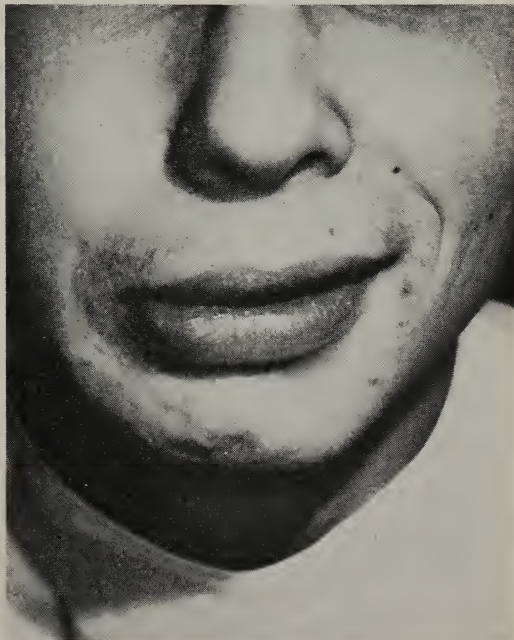


FIG. 1. Patient's face showing right facial paresis and swollen lower lip.

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in addition to the classic, complete triad of facial paralysis, facial swelling and lingua plicata, cases showing (1) facial palsy and edema without scrotal tongue (such as the case reported herein), (2) facial edema and scrotal tongue without paralysis, and (3) facial paralysis and scrotal tongue without edema should be considered atypical and incomplete forms of this syndrome. They stated that lingua plicata is the "most perplexing" and least constant part of the triad, varying in its presence from 25 to 100 per cent in previously reported series.

The facial paralysis is usually sudden and often complete with onset in childhood,<sup>5</sup> as in the case presented here. It is unilateral or bilateral, often recurrent, and nearly always peripheral in type and thus indistinguishable from Bell's palsy.<sup>4</sup> Unlike the present case, it usually regresses completely. One report was found of an apparent *forme fruste* with bilateral peripheral, *ninth* cranial nerve paralysis associated with scrotal tongue and macrocheilia.<sup>6</sup>

The edema is brawny, unilateral or bilateral, usually fairly abrupt in its onset and usually recurrent.<sup>4</sup> Although most frequently involving the lips (especially the upper), it may involve any area of the face or tongue. In his review of 60 cases Hornstein<sup>7</sup> reported involvement of backs of the hands, breast, anal area, larynx, and even bronchi. Although microscopic examination of the swollen tissue may disclose the sarcoid-like granulomas of Miescher's cheilitis granulomatosa, the usual picture is lymph-

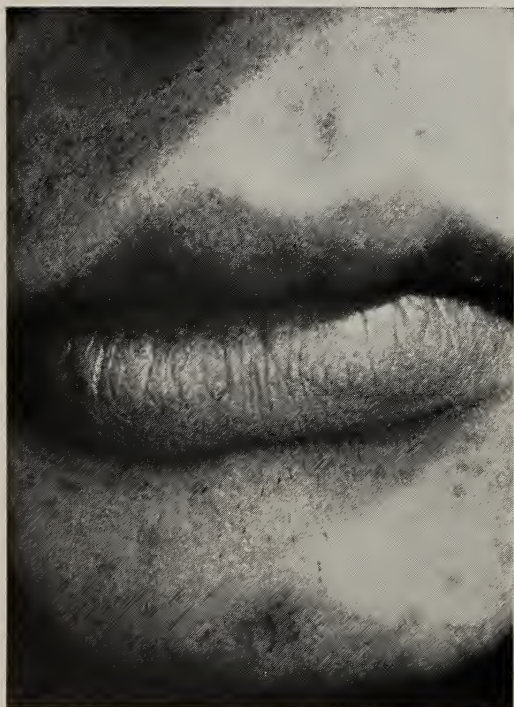


FIG. 2. Close-up of patient's lower face showing changes in lips.



FIG. 3. Patient's tongue showing absence of lingua plicata.

edema, lymphangiectasia, and chronic nonspecific inflammatory infiltration,<sup>8</sup> as was found in the present case. Wallk and Bluefarb<sup>9</sup> list an excellent differential diagnosis of the facial edema which includes cheilitis granulomatosa (which they believe is very closely related to Melkersson-Rosenthal syndrome), Ascher's syndrome (edema of the upper lip and upper eyelids, blepharochalasis, and hyperplastic labial salivary glands), "double lips," hemangiomas and lymphangiomas, cheilitis glandularis apostematosa, poor dental hygiene with lip involvement, and "solid edema" (lymphedema following recurrent erysipelas). In addition, mention might be made of erysipelas itself, angioneurotic edema, acromegaly, myxedema, pachydermoperiostosis, actinomycosis and other deep mycoses, and contact cheilitis in the differential diagnosis, although usually this syndrome is easily recognizable. Therapy for the edema has not been outstandingly successful<sup>4</sup> and has consisted chiefly of such modalities as plastic surgical revision and x-ray therapy.<sup>5</sup> In addition to surgery and x-rays, New and Kirch<sup>10</sup> injected boiling water into the edematous facial tissues, claiming "satisfactory" results.

Although theories of etiology of the Melkersson-Rosenthal syndrome have included "allergic reactions, syphilis, lymphogranuloma inguinale, basal arachnoiditis, benign lymphogranulomatosis, and bacterial infection of the teeth and throat"<sup>4</sup> as well as severe cerebral trauma,<sup>11</sup> psychic factors,<sup>12</sup> congenital toxoplasmosis<sup>13</sup> (the latter convincingly refuted by Kern<sup>14</sup>), "the etiology remains obscure."<sup>4</sup> The most



frequently elicited etiologic theory is that there is some autonomic nervous system dysfunction<sup>4,9,15</sup> in the area of the involved facial nerve and skin. Kettel<sup>16</sup> apparently felt that paralysis of the sympathetic vasomotor nerves to the face results in secondary angioneurotic edema of the face and paresis of the vascular supply to the facial nerve with damage to the nerve and peripheral facial palsy. Cairns<sup>15</sup> suggested autonomic overactivity might induce vasospasm and neural ischemia with later vasodilation causing edema with resultant compression of the facial nerve in the fallopian canal. He mentioned the not infrequent association of migraine, vertigo, and lachrymal hypersecretion with this syndrome as evidence suggesting autonomic dysfunction in these patients. Rothman believed it to be a "neurotropic disturbance following facial nerve palsy."<sup>17</sup>

As mentioned earlier, *lingua plicata* is the least constant finding in the syndrome and it was not

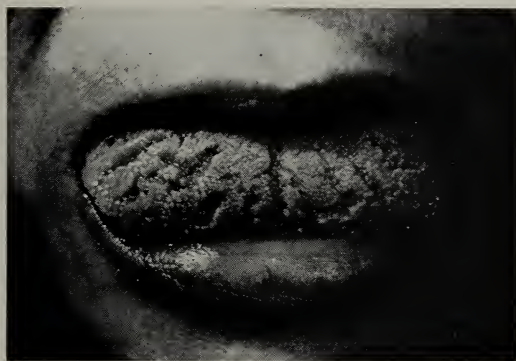


FIG. 4. Patient's mother's tongue showing *lingua plicata*.

present in this patient. However, its presence in his mother and maternal grandmother seemed interesting and raised the possibility that they might have very incomplete forms of this syndrome with only the scrotal tongue, and, as a corollary, that the Melkersson-Rosenthal syndrome might be hereditary. Accordingly, a search of the literature was made to gather evidence for or against this theory.

According to Cockayne,<sup>18</sup> scrotal tongue is an hereditary anomaly with the inheritance pattern of an "irregular dominant." It occurs in 0.5 per cent of the general population with equal distribution between the sexes.<sup>19</sup> Ekblom<sup>1</sup> stated that the father of one of his eight patients with Melkersson-Rosenthal syndrome had a plicated tongue and that, "A few of the patients were aware of this anomaly in some of their relatives. I did not, however, make investigation of the heredity by means of a study of the relatives." Of Rosenthal's three cases, one patient's mother and sister had scrotal tongues and the sister had facial palsy in addition.<sup>1</sup> Another patient's sister had the "same symptoms" (apparently the full triad, but presumably not personally verified by Rosenthal). In Midana and Bonu's<sup>6</sup> case report,

scrotal tongue was a familial occurrence, being present in the patient and in his mother, sister, uncle, and maternal grandmother. McGovern<sup>5</sup> stated, "The anomaly of the tongue appears long before the onset of the facial edema and Bell's palsy and probably is of hereditary nature." This begs the question: if scrotal tongue is hereditary and also is a definite part of the Melkersson-Rosenthal syndrome, then isn't it possible that the entire syndrome is hereditary?

Turning briefly to the other parts of the triad we note that New and Kirch,<sup>10</sup> in reviewing 67 cases of permanent swelling of the lips and other parts of the face in 1933, reported that 13 had had facial paralysis and "one patient stated that a brother had the same condition." McGovern<sup>5</sup> stated that the facial paralysis of Melkersson-Rosenthal syndrome may be familial. In discussing the nature of Bell's palsy itself, Hilger<sup>20</sup> has suggested that this neurological disorder is due to vasospasm secondary to an inherent tendency for facial autonomic nerve dysfunction. Also migraine, a frequently familial vasomotor process, may be associated with Melkersson-Rosenthal syndrome.<sup>10,15</sup>

Although several of the reported patients have had family members with some part of the syndrome, and, although one feature of the triad (scrotal tongue) is clearly hereditary, review of the literature failed to uncover any previous suggestion that the Melkersson-Rosenthal syndrome itself might be hereditary. The patient reported herein presented

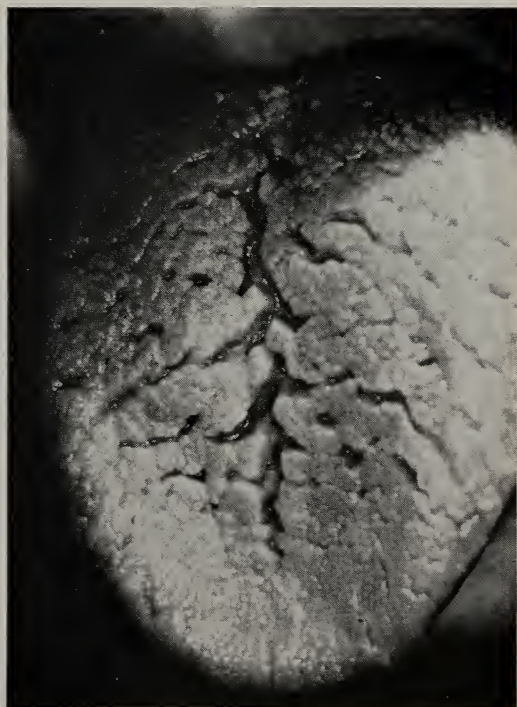


FIG. 5. Patient's maternal grandmother's tongue showing *lingua plicata*.

two thirds of the complete syndrome (facial paralysis and edema), while his mother and maternal grandmother had the manifestation missing in him (scrotal tongue). Although somewhat apologetically aware of the lack of solid supporting evidence, I should like to raise several possibilities for consideration viz: (1) that the patient's mother and grandmother may have extreme formes frustes of the Melkersson-Rosenthal syndrome; (2) that the syndrome may have been genetically transmitted in incomplete form (lacking the scrotal tongue) to the patient; (3) that the genetic mode of transmission most likely would have been a simple autosomal dominant with varying degrees of expressivity; and finally, (4) that, since the facial nerve deficit and lip edema developed several years after birth, the condition in this case may be an abiotrophy of the autonomic nervous system. Perhaps future cases of this condition can be studied to greater advantage with these possibilities in mind. The normal chromosomal analysis appears to rule out recognizable chromosomal abnormality in this case.

### Summary

A patient with Melkersson-Rosenthal syndrome (showing facial paralysis and edema of the lower lip), whose mother and maternal grandmother have lingua plicata, is presented. The literature on this symptom-complex is reviewed, with special emphasis on familial occurrence and etiologic theories. The possibility that Melkersson-Rosenthal syndrome may be an hereditary process is raised for consideration. Chromosomal analysis failed to reveal any abnormality in this patient.

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**T**O THE SURGEON the ability to operate with a high degree of safety upon practically any part of the body has led, naturally, to the desire to treat diseases that previously, by default, had been managed exclusively by the physician. Thus, a pattern develops as follows: an attack on a medical disease is launched by the surgeon; the first patients do very well; triumph is proclaimed; the physician awakens and reviews for the first time, critically, the results of his own stewardship and is seldom pleased; he discovers that relatively little is known about the disease; investigations are undertaken by both surgeon and physician, usually with conflicting results; the value of operative treatment is seriously questioned; the surgeon withdraws to a carefully prepared position bounded by certain clear-cut indications for operation; patrol activity continues.

How often has one looked with interest and amusement upon that pattern in recent years, for into it can be fitted the recent history of the treatment of such common diseases as peptic ulcer, some cardiac diseases, hypertension, ulcerative colitis, obstructive vascular disease and a variety of endocrine and hematologic disorders?

Without conceding for a second that the contribution of surgery to the relief of these conditions is not great, I suggest that even if operation formed no part of their treatment when the issue was finally settled, much credit should go to the surgeon whose temerity in the first place incited the physician to examine his own affairs. — H. Locke Robertson, M.D., Montreal, Quebec: *The New England Journal of Medicine*, 272:1029-1036, May 20, 1965.



# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

C. R. MACPHERSON, M.D., *President*

## PRESENTATION OF CASE

THIS white man, aged 58, entered Ohio State University Hospital with a chief complaint of weight loss of approximately 60 lb., anorexia, and fatigability for the past three to four months. At this time he had an evaluation by his family physician with barium enema, upper gastrointestinal and chest x-rays, all of which were considered normal except for emphysema and pulmonary fibrosis. Three days prior to admission the patient had marked anorexia associated with nausea and vomiting. On the day before admission he developed right lateral chest pain associated with nonproductive cough. Prior to his illness he had been drinking a half pint of wine per day. He did not smoke.

## Physical Examination

The patient was pale, thin, and appeared chronically ill. His blood pressure was 110/70, his pulse rate 80 per minute and regular, the respiratory rate 20/min., and temperature 98.6°F. The skin, head, eyes, ears, nose, throat and neck showed no abnormalities. The chest was increased in anteroposterior diameter with poor expansion; there were inspiratory and expiratory wheezes and rhonchi throughout both lung fields. There was dullness with absence of breath sounds over the right posterior and lateral chest; no rales were heard. The heart had a regular sinus rhythm; no cardiomegaly was noted. The first and second heart sounds were normal; no friction rub or gallop rhythm was present. The liver, spleen, and kidneys were not palpable, nor were other abdominal masses felt. There was no remarkable adenopathy. On neurologic examination the cranial nerves were intact, the deep tendon reflexes were increased throughout; no pathologic reflexes were noted.

## Laboratory Data

The hemoglobin was 14.7 Gm., the hematocrit 48 per cent, the white blood cell count 7,219 with 71 per cent neutrophils, 20 per cent lymphocytes, 7 per cent monocytes, and 2 per cent eosinophils. The urine had a specific gravity of 1.025, and was normal. The

## Presented by

- Robert J. Atwell, M.D., Columbus, and
  - Emmerich von Haam, M.D., Columbus;
- Edited by Dr. von Haam.

blood urea nitrogen was 18 mg., the creatinine 1.6 mg., and the fasting blood sugar 79 mg./100 ml. The serum sodium was 141, potassium 5.5, chlorides 99, and the CO<sub>2</sub> combining power 35 mEq./liter. The inorganic phosphorus was 3.2 mg./100 ml. with an alkaline phosphatase of 12.7 units and acid phosphatase of 1.0 units. The serum glutamic oxalacetic transaminase was 26 units. Bromsulphalein test showed 1.9 per cent retention. The serum serology was nonreactive.

The electrocardiogram demonstrated flat T-waves with a wide QRS-T angle. Repeated electrocardiograms throughout his hospital course showed no essential change.

Chest x-ray showed the heart and mediastinum to be within normal limits. The aorta was tortuous and arteriosclerotic. There were bilateral infiltrates of the lower lung fields with a right pleural effusion. This was interpreted as compatible with bronchial disease such as chronic bronchitis or bronchiectasis.

## Hospital Course

At the time of admission a Gram stain of the sputum showed many polymorphonuclear leukocytes and some very large cells with large nuclei that were suggestive of malignant cells. During the first week the patient had intermittent episodes of nausea and vomiting. The vomitus was guaiac-negative. An upper gastrointestinal x-ray series showed a normal stomach and esophagus. The duodenal loop appeared to be slightly dilated with no peristalsis at the region of the ligament of Treitz. Multiple dilated loops of ileum and jejunum and dilatation of the first and second portions of the duodenum were also noted. The findings suggested a superior mesenteric artery

Submitted July 15, 1965.

syndrome or a possible ileus secondary to an inflammatory disease in the abdomen. Films taken in lateral projection showed an increased retrogastric space and an enlarged left kidney. There was no enlargement or compression of the duodenal loop suggestive of a pancreatic neoplasm. A skeletal survey showed no evidence of bony metastasis.

The patient continued to have episodes of nausea and vomiting. In the second week of hospitalization the serum sodium was 122, the potassium 4.0, the chlorides 87, and the  $\text{CO}_2$  combining power 30 mEq./liter. With intravenous fluid therapy his electrolytes returned to normal. A bronchogram was attempted on the tenth hospital day and the films were suggestive of partial collapse of the right lower lobe. This procedure had to be terminated because of sudden apnea and cardiac arrest. The patient was resuscitated and returned to his room. Because of difficulties with secretions following the resuscitation a tracheostomy was performed.

On the twelfth hospital day a succussion splash was noted in the left upper quadrant. A Levin tube was inserted and 2000 cc. of fluid was aspirated. The patient was continued on low suction. Repeat chest x-ray at this time showed a marked increase of consolidation in the lower lung fields, particularly on the right. On the thirteenth hospital day another bronchoscopy was attempted; however, the patient was unable to tolerate the procedure because of marked shortness of breath. An intravenous pyelogram showed obstruction at the midportion of the left ureter without evidence of a mass or calculus.

Throughout the remaining hospital course the electrolytes remained within normal limits. The serum calcium was 4.5 mEq./liter. A repeat alkaline phosphatase was 9.9 units. Numerous sputum cultures showed a light growth of normal flora; acid-fast cultures were also negative. Cytologic examination of the sputum was reported as Papanicolaou Class IV. During his last four days of hospitalization the patient had intermittent episodes of confusion and lethargy. The gastric aspirate was dark green and guaiac-negative. On the sixteenth hospital day he developed increasing respiratory distress, which improved somewhat with oxygen therapy by way of the tracheostomy. He continued afebrile. The blood pressure remained 110/84 and the pulse rate was 100 per minute. During his last 24 hours (18th day) he became hypotensive and unresponsive to Aramine® and Levophed®. Increasing cyanosis was associated with increasing respiratory distress. The patient became unresponsive, apneic, and developed cardiac standstill. Attempts at resuscitation were unsuccessful.

#### CLINICAL DISCUSSION

DR. ATWELL: We have before us a 58 year old white man with complaints of rather marked weight loss, anorexia, and fatigability for three to four months. His symptoms at the onset were so severe

that his family physician went to some lengths to find out what was causing this man's complaints and only discovered relatively minimal changes in his chest x-ray at the time when his G. I. symptoms really were quite marked. This fact I think is probably significant in the overall consideration of this case. Then his nausea and vomiting became much more severe, and he developed right lateral chest pain. I don't think that his alcohol intake really enters into the picture and we'll pass it over. He did not smoke.

When he came in here he appeared quite thin, pale, and chronically ill. Other than the chest findings, no physical abnormalities were noted. His liver and spleen were not enlarged, and no abdominal masses were palpated. As for his chest findings, one would wonder whether the increased anteroposterior diameter and the poor expansion were really related to emphysema or whether he had just a big, rigid lung as the result of something infiltrating the lungs. The finding of rales and rhonchi means only that he had bronchospasm or obstruction of the airways due to secretions.

From his laboratory data we gather that he was not anemic, that he had a normal white count, a normal urine, and really the only abnormality was that of a slightly elevated alkaline phosphatase. I would like to have Dr. Dunbar interpret the x-ray findings.

#### Discussion of X-Rays

DR. DUNBAR: The preliminary chest films showed the heart and mediastinum within normal limits. There were bilateral lower lobe pulmonary infiltrates with right pleural fluid or thickening. The follow-up films include chest films which showed extension of the bilateral mid-lung and basilar infiltrates with some increase in the right-sided pleural fluid and the presence of a tracheostomy tube. The bronchogram was not complete due to the patient's difficulty during the procedure, but we do not recognize any major bronchial obstruction on these spot films. The changes in alveolar cell carcinoma are sometimes fairly specific on bronchograms where there are numerous small nodules throughout the involved areas of the lung, but the filling in this bronchogram is not sufficient for any really objective opinion.

Considering all his chest films and his bronchogram, I would say it is possible that the changes present are inflammatory in nature, but I consider this rather unlikely. There are multiple B-lines present in both lower lung fields indicating lymphatic or venous obstruction and entirely consistent with widespread lymphatic metastases. I feel the films are most consistent with lymphatic pulmonary metastases or primary pulmonary alveolar cell carcinoma.

DR. ATWELL: Do you think this man had chronic bronchitis?

DR. DUNBAR: He did. He had some mucous gland filling and I presume there were some secre-



tions in these bronchi. They are not too spastic but there is evidence of bronchitis, yes.

DR. ATWELL: Why don't you go ahead and discuss the rest of his films?

DR. DUNBAR: His upper G. I. films showed a large stomach; it has some heavy folds in the fundus but we don't think this means a neoplasm. His distended duodenum suggests the possibility of obstruction in the third and fourth portions of the duodenum. I would say that the stomach is too big to be normal and supports the diagnosis of some obstruction over a long period of time.

DR. ATWELL: Do you think that the obstruction you see in the third or fourth part of the duodenum is causing the enlargement of the stomach?

DR. DUNBAR: Yes, I do. I have additional hints to help me say that. The pyelogram showed normal kidneys except for hydronephrosis on the left side. Neither of the kidneys showed evidence of a mass. We did have bone surveys the next day after the pyelogram and you can see the residual contrast media in the ureters. The left ureter is obstructed right there in its midportion. This to me means that the problem is retroperitoneal. I think this man does have a tumor in his left retroperitoneal area in the area of the left kidney, and this makes me think that the abnormality in the region of the duodenum is also neoplasm. Since I consider his chest lesions as neoplastic, I tend to think that the rest of what I see is probably also neoplastic.

His last film shows a huge stomach projecting clear into the pelvis. This to me means that he has severe obstruction of the stomach or duodenum, and from the original films I think it is in the duodenum. I think he has progressively occluded the fourth part of his duodenum.

DR. ATWELL: In your experience, what is the most common cause of obstruction in the third and fourth portions of the duodenum?

DR. DUNBAR: Carcinoma of the pancreas or metastatic carcinoma from carcinoma of the colon or in widespread carcinomatosis.

DR. ATWELL: You don't think, as was suggested in the x-ray report later on, that this was a mesenteric artery syndrome?

DR. DUNBAR: That is a rather rare lesion. I have seen it in very skinny young people but I have never seen it in this age group.

DR. ATWELL: Well we had better move along here. His hospital course was one of gradual progression of his difficulties. He continued with severe nausea and vomiting and as a result of this his electrolytes apparently suffered but were corrected. After his bronchogram he probably blocked off his bronchi and had hypoxia and cardiac respiratory difficulties. He then developed a succussion splash,

and they found a great big, dilated stomach, intubated him and sucked him out. He became steadily worse with hypotension, lethargy, and unresponsiveness and eventually died on the eighteenth hospital day.

### Summary

*In summary* then, we have here a 58 year old man with a relatively short history of weight loss, anorexia, nausea and vomiting. At the time he came in here, contrary to his history which is one primarily of G. I. tract difficulties, all his abnormal physical findings pointed to a disease of the respiratory tract. Although he was in the hospital for 18 days with a pleural effusion, he never had a chest tap let alone a pleural biopsy. I dare say that we really missed our chance to make a diagnosis in this patient at that time, because I think from the fluid and a pleural biopsy we could have established a diagnosis. This would have been a much more logical approach to this problem than a bronchogram or bronchoscopy.

His chest x-rays showed a bilateral, symmetrical infiltrating process with lymphatic obstruction. We found obstruction of the third or fourth portion of the duodenum and obstruction of the midportion of the left ureter with a left hydronephrosis. It seems to me that from his history I would agree with Dr. Dunbar that this man started off in all probability with a process in his abdomen causing some type of obstruction to his bowel before he ever had anything in his lung.

What could be going on here? Certainly a retroperitoneal tumor of some sort would be the most likely thing that could produce intestinal obstruction, obstruction to the ureter, and the so-called lymphangitic pattern of carcinomatosis in the lungs. Could this be a primary tumor of the lung? Yes, a very small bronchogenic carcinoma can show extensive lymphangitic spread and also extensive metastasis to the adrenals. But since he started off with abdominal symptoms and really nothing in his lungs, I don't think he suffered from a primary bronchogenic carcinoma. Alveolar cell carcinoma of the lung can give you diffuse and extensive involvement of the lung, but it ordinarily does not metastasize to produce bowel obstruction and the patient would probably be dead because of respiratory distress before he could get extensive abdominal metastasis.

Lymphangitic spread of carcinoma to the lung is most common in carcinoma of the stomach, pancreas, adrenal, or prostate. Hodgkin's disease or lymphosarcoma can also sometimes give you a similar picture. We did not see anything suspicious in the stomach, and it would have to be carcinoma of the body of the pancreas and not of the head. We don't see any masses in relation to the kidneys, and ordinarily the prostate will give you bone involvement before it involves the lung to this extent. Retroperitoneal lymphosarcoma could very possibly do this, while Hodgkin's disease would produce more confluent and

invasive lesions in the lung with involvement of the mediastinal glands.

So we conclude that this patient had some sort of primary retroperitoneal tumor which involved the left ureter and duodenum and then invaded both lungs through the lymphatics, and in the order of the various possibilities I would mention, first, a retroperitoneal lymphoma; second, a tumor of the body of the pancreas; third, a carcinoma of the stomach.

#### General Clinical Discussion

QUESTION: What about his elevated alkaline phosphatase?

DR. ATWELL: It came down later and I can't really get very excited about it. If it was due to extensive neoplastic involvement it should have either stayed up or gone higher.

QUESTION: How often do you see carcinoma of the body of the pancreas without pain?

DR. ATWELL: It usually will give you back pain like any tumor in the retroperitoneal space. How frequent it is, I don't know.

DR. RUPPERT: The most rapidly progressive painless tumor we know is usually from the body of the pancreas.

DR. ATWELL: Maybe we should have put the pancreas at the top of the list.

QUESTION: Would a tumor that invades the lungs through the lymphatics give you a Class IV Pap smear in the sputum?

DR. ATWELL: If this tumor invades the bronchi the cells may exfoliate into the bronchial tree and appear in the sputum.

DR. VON HAAM: We have diagnosed metastatic choriocarcinomas and hypernephromas from the sputum.

#### CLINICAL DIAGNOSIS

Retroperitoneal malignant neoplasm with: (1) obstruction of the duodenum; (2) obstruction of the left ureter; (3) lymphatic spread to the lungs.

#### PATHOLOGIC DIAGNOSIS

Carcinoma of the body of the pancreas with extensive metastasis to liver, lymph nodes, left adrenal, left kidney, left ureter, and both lungs.

#### DISCUSSION OF PATHOLOGY

DR. VON HAAM: The body appeared well developed but cachectic. The abdominal cavity showed a very large tumor mass which replaced the body of

the pancreas and caused obstruction of the small intestine at the duodenojejunal junction. The tumor also extended into the retroperitoneal space, replaced the left adrenal gland, metastasized to all retroperitoneal lymph nodes, and formed tumor metastases at the hilus of the left kidney and in the wall of the left ureter. The liver also showed numerous small metastatic nodules. The lungs were studded with numerous small nodular metastases, and all bronchi showed neoplastic invasion of the peribronchial lymphatics. Both pleural cavities contained slightly turbid fluid, and the walls of the thoracic cavity showed diffuse infiltration with grayish-white tumor tissue.

Histopathologic examination revealed an adenosquamous carcinoma of the pancreatic ducts destroying the entire body of the organ. Both gland-like structures with mucous secretion and squamous-like cell nests were present. All acinar tissue was destroyed, while some of the islands could be distinguished. All metastatic nodules were of similar histologic type although they varied somewhat in their proportion of adenocarcinoma and squamous-cell carcinoma. Histologic examination of the lungs revealed, in addition to the widespread metastases, neoplastic changes in the bronchial mucosa suggestive of a multicentric carcinoma *in situ* with squamous-cell metaplasia of the bronchial mucosa. There were also extensive areas of confluent bronchopneumonia. Examination of the gastric mucosa showed abnormal glandular formations in some of the prominent gastric folds suggestive of carcinoma *in situ* of the stomach. Examination of the prostate showed an adenocarcinoma arising in the posterior lobe and invading the pericapsular tissues of the gland.

So we have here a patient who died from an extensive adenosquamous carcinoma of the body of the pancreas with metastases to the liver, lung, and lymph nodes, producing intestinal obstruction and obstruction of the left ureter. These findings confirm the diagnosis of our clinical discussant. However, in addition to the obviously fatal tumor, the patient suffered from carcinoma *in situ* of the stomach and the bronchial tree and invasive carcinoma of the prostate. The carcinoma *in situ* of the bronchial tree was responsible for our cytologic findings. I think this case supports well Shields Warren's concept that a patient who has been cured of one carcinoma has a greater chance of developing a primary cancer in another organ than an individual of the same age has of developing a first malignant tumor.

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**B**IOPSY OF THE INTERNAL MAMMARY LYMPH NODES is a simple, reliable method to confirm a diagnosis in cases of pleural effusion and is especially valuable in cases with tuberculous pleurisy. It is indicated in any case of pleural effusion in which the usual diagnostic modalities do not provide a diagnosis. — E. F. Conklin, M. D., et al., New York City: *The New England Journal of Medicine*, 271:1346-1348, Dec. 24, 1964.



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3 to 6 months—3 mg. ( $\frac{1}{2}$  tsp.\* t.i.d.)  
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1 to 2 years—5 mg. ( $\frac{1}{2}$  tsp. 5 times daily)  
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20 mg. (2 tsp. 5 times daily or  
2 tablets 4 times daily)

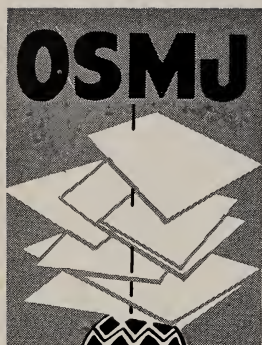
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# NEWS AND *Organization Section*

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## Marathon Session of Ohio Legislature Good Record in Medical-Health Field

By HART F. PAGE and W. MICHAEL TRAPHAGAN

THE longest session of the Ohio General Assembly in contemporary times, superimposed on a two-month special session of the previous legislature in waning 1964, came to an end September 1, with a favorable record of health and medical legislation.

The 106th regular session was a busy one for medicine from the very outset. During the first week of February, the Ohio State Bar Association and other groups attempted to rush through a bill to extend the statute of limitations for malpractice and other actions from one to two years. After a hectic week for OSMA, spent in producing testimony, rallying allies and excellent work by physicians and medical societies in the home counties of the members of the Judiciary Committee, the measure, (H. B. 30), was killed in that committee 12-9.

Later in the month of February, Rep. Huffer (Pickaway County) introduced H. B. 342, to provide that hospital medical records be made available at "all reasonable times" to patients, attorneys representing patients, and "any other person authorized by a patient, or his parent or guardian if such person is legally incompetent." This bill was able to survive the Judiciary Committee, but a strong combine of medical, hospital and allied organizations carried the battle to the floor of the House, where key Representatives dissected it to the extent that it was rejected 113-14, perhaps the worst defeat handed to a House measure in current history.

### OSMA Bill Becomes Law

Capably handled by Rep. Keith McNamara (Franklin County), H. B. 373, OSMA's bill to make it un-

necessary for voluntary cancer registries to report in the Central Registry operated by the Ohio Department of Health, became a law and was effective September 28.

### Leaders Helpful

To House Speaker Roger Cloud of Bellefontaine and to those who assisted him goes much of the credit for the sound and constructive medical and health outlook of the House of Representatives.

Senator Theodore M. Gray, in his first session as President Pro Tem of the Ohio Senate, approached his difficult task with patience, dignity, and good judgment. Facing a 16-16 party alignment in the Senate, he was able to carve out a legislative program which has received much commendation around the State House.

Representative Clara E. Weisenborn, Dayton, serving her third term as chairman of the House Health Committee, again commanded the loyalty and respect of members of both parties. Veteran members of the committee who were of great assistance included: Carlton Davidson, Lawrence County, vice-chairman; Rep. McNamara; Raymond E. Hildebrand, Lucas County; Anne M. Donnelly, Cuyahoga County, and Myrl H. Shoemaker, Ross County. Four veteran legislators, all familiar with medical and health affairs, added to committee strength this year: Herman K. Ankeney, Greene County; David Weissert, Muskingum County; Walter L. White, Allen County, and Robert E. Netzley, Miami County. Three freshmen legislators, Jerry O'Shaughnessy, Franklin County, who was elected secretary of the committee, Henry



T. Dombrowski, Cuyahoga County, and Ralph Turner, Summit County, were excellent additions.

Members of the Senate Committee on Education and Health who were helpful on medical and health legislation were Chairman Oakley C. Collins, of Ironton; Senator Max H. Dennis, Wilmington; Vice-Chairman Oliver Ocasek, Northfield, and Senators Charles W. Whalen, Jr., Dayton, and Robert E. Stockdale, Kent.

### **"Back Home" Help Made the Difference**

As in the past, a legislative bulletin was issued each Thursday from OSMA headquarters to county medical society officers and legislative committee chairmen.

The bulletins covered the status of medical and health bills and suggested follow-up procedures in contacting legislators who were home for the weekend.

Special bulletins, wires, and telephone calls supplemented the regular bulletins on key issues at appropriate times.

The work of the legislative machinery of the Ohio State Medical Association and its county medical societies again proved that the strength of a legislative program depends upon the efficient functioning of local chairmen and society officers, assisted by society members who have the "ear of their legislator."

As has been traditional, all measures in the medical and health field were closely followed by the representatives of the Ohio State Medical Association.

Bills were sponsored, supported, or opposed in accordance with the policies of the Association as determined by The House of Delegates and The Council.

The legislative representatives of the Association were on duty at the State House while Committee hearings and House and Senate sessions were under way. Many times accompanied by physician witnesses, they appeared at countless committee hearings, testifying on bills, supplying information, and suggesting amendments for improvement of legislation. Also, there was considerable contact with individual legislators.

### **Reapportionment Fails**

In all, 456 bills were passed. The Governor vetoed eight bills. Therefore, bills enacted into law totaled 448.

All attempts by the Ohio Legislature to comply with the U.S. Supreme Court's decision requiring legislative districts to be nearly equal in population, failed. Basically, the failure was caused by almost total Democratic opposition to sub-districting of the large Ohio counties—Cuyahoga, Franklin and Hamilton.

Because of the failure of the legislature to adopt a reapportionment plan, U.S. District Court Judge Carl Weinman announced September 8 that a three-judge panel would draft a plan. The three judges; Weinman of Dayton, Paul Weick of Akron and John

Peck of Cincinnati, were scheduled to begin work on the plan October 1.

### **Welfare Reorganization Bill Passed**

Am. Sub. H. B. 376, a bill which transferred the administration of various programs of the Ohio Department of Public Welfare from the state to the county level, was made law after several months of hearings.

The law transfers the administration of aid for the aged to county departments of welfare; abolishes city relief authorities; establishes a uniform system for financing the local share of federally aided public assistance costs and of poor relief costs; abolishes mandatory levies and other former provisions for financing such programs; provides for all the public utility excise tax revenues to be retained by the state; gives the Ohio Department of Public Welfare additional supervisory powers over county welfare departments and makes other related changes in the public assistance laws.

Senate sponsor Max Dennis, Wilmington, pointed out that the counties are retained as the administrative unit which, he said, is important to keep welfare at the local level. He said the bill does not increase standards on assistance, change the lien laws or the residency requirements.

### **Appropriations in Health Field**

With regard to appropriations of interest to the profession, the Ohio Department of Health received \$2,878,235 for each year of the 1965-1967 biennium or a total of \$5,756,470. Set aside for health care under the Division of Aid for Aged of the Department of Welfare was \$22,500,000 for 1965-1966 and \$24,000,000 for 1966-1967, an increase of \$6,126,000 for the biennium.

Fifty thousand dollars was allotted to The Ohio State University for a "chair for general practice." The Toledo State College of Medicine received \$100,000 for 1965-1966 and \$150,000 for 1966-1967.

The State Medical Board received \$60,335 for 1965-1966 and \$57,985 for 1966-1967. The Division of Mental Hygiene, Ohio Department of Mental Hygiene and Correction, received \$149,096,000 for the biennium; \$74,423,000 for 1965-1966 and \$74,673,000 for 1966-1967.

### **Legislative Service Commission**

A bill intended to "return the Legislative Service Commission to the Legislature" was enacted into law with the support of OSMA. Am. S. B. 328, sponsored by Sen. William H. Deddens, Hamilton, provides that no committee study or report shall be published by the Commission until it has been approved by a majority of the committee (of legislators) making the study, and by a majority of the Commission, which is made up of members of the House and Senate.

Appointees to the Legislative Service Commission for 1965-1966 are: Senators Garrigan (Akron),

Hoffman (Cincinnati), Whalen (Dayton), King (Toledo), Carney (Youngstown) and Miller (Cleveland); Representatives Jump (Huron), Reckman (Hamilton), Kerns (Union) Cassel (Wyandot), Lancione (Belmont) and Thomas (Summit).

### PKU Testing

Beginning on July 1, 1966, a law enacted by the 106th session requires compulsory screening of all newborn infants for phenylketonuria. The emotional appeal of Am. Sub. S. B. 19 made it difficult for OSMA to obtain assistance from its natural allies in opposing it. Further, an eleventh hour endorsement by the Ohio Academy of General Practice and a special letter from the OAGP urging passage of the bill arrived at legislators' desks on the morning the bill was scheduled for a vote. This damaged efforts to point out defects of the bill which OSMA considered incompatible with good medical practice.

Excellent testimony in opposition to the bill was presented to the House Health Committee by Drs. Homer A. Anderson, William J. Rueger and William Newton, Jr., all of Columbus.

Regulations to implement this bill must be adopted by the Public Health Council. OSMA will be present at the public hearing on these regulations and will present constructive criticism, if necessary.

### Physician Ownership of Pharmacies

H. J. R. 37, a resolution that would have requested the "American Medical Association to include in its Code of Ethics a provision prohibiting physicians from owning or participating in the retail drug business . . .," was killed by a House Committee, 12-0. This resolution was opposed by both OSMA and the Ohio State Pharmaceutical Association.

Section 7 of the AMA Principles of Medical Ethics now provides: "Drugs, remedies or appliances may be dispensed or supplied by the physician provided that it is in the best interests of the patient." Under this language it is not considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of the patient.

The OSMA and Ohio State Pharmaceutical Association are working together to prevent abuse in this field. At a joint meeting of the Interprofessional Relations Committee of OSPA and the OSMA Committee on Public Relations and Economics held November 15, 1964, it was agreed that physician ownership "did not presently constitute a problem in Ohio and that the associations should be alert to ways to prevent undesirable practices from developing.

### Mandatory Nurse Licensure

Senate Bill 197, which would have provided for the mandatory licensure of all professional and practical nurses, died in the Senate Rules Committee with the closing of the legislative session.

OSMA opposed this bill as one that would create

an "insurmountable burden" for the physicians in all areas of the state, both rural and urban. The definition of "practice of nursing" in one section of the bill was such that a physician's office nurse would of necessity have to obtain a license as a "Registered Nurse," or, in some instances, as a "Licensed Practical Nurse," or lose her job. With the recognized shortage of registered nurses, the physician would have nowhere to turn for help. In addition, hundreds of well-trained office assistants would be thrown out of work, with the only alternative being long years of formal training in order to qualify for re-employment.

### Corporate Practice Bill Dies

A bill to license corporations to engage in the practice of medicine, S.B. 14, died in the Senate Rules Committee at the closing of the Legislative session. This bill was actively opposed by OSMA. It was the opinion of The Council that enactment of the bill would not improve the chances of getting Treasury approval of pension plans and profit-sharing plans for medical corporations and their physician shareholders.

It was also felt that it would impair and weaken the "public image" of the medical profession as a profession of men occupying a very personal and confidential relationship with their patients . . . a professional relationship as opposed to the purely business relationship that typifies and characterizes corporations generally. It would tend to bring another "third party," the corporation, between physician and patient.

### Health Districts

Defeated in the House in early June, was H. B. 173, which would have increased the minimum population to constitute a city health district from the present 5,000 to 25,000. For a number of years, OSMA has supported the principle of this legislation, but strong opposition has come from cities reluctant to give up their own existing health departments.

### Criminal Insanity

H. B. 473, which would have established a new test for criminal insanity and do away with the present "McNaughten Rule," was defeated in the House Judiciary Committee. OSMA legal counsel testified against this bill, explaining that OSMA opposition was based on the opinion that the standards proposed by the measure were too vague, too broad and too difficult to apply. The bill was backed by the Ohio State Bar Association and the Ohio Psychiatric Association. OSMA was the only organization to appear in opposition.

### Board Bills Defeated

H. B. 564, to establish a central organizational unit to carry out the administrative functions of the various professional and occupational boards, leaving the professional activities in the hands of the board



secretaries, died with the closing of the legislative session. It received no action by the Senate Committee on State Government to which it was referred on May 24. OSMA approved this bill in principle, after obtaining several constructive amendments.

H. B. 621, to establish uniform re-registration procedures for occupations and professions which are required to register each year, was defeated in the Senate. This bill would not have directly affected physicians. However, allied health personnel would have been affected.

#### Birth Control Bill Enacted

H. B. 120, OSMA-supported bill to legalize the sale or distribution of drugs and articles for the prevention of conception, was passed almost unanimously by both houses of the General Assembly. For complete details on this new law, see the September, 1965, issue of *The Ohio State Medical Journal*, page 837.

#### Building Standards

S. B. 124, OSMA-supported bill calling for the Board of Building Standards to adopt standards, rules and regulations to facilitate the free and unobstructed access and use of all public buildings and facilities by handicapped persons, was signed by the Governor on July 28 and becomes effective on October 28.

A resolution supporting this concept was passed by the OSMA House of Delegates at the 1965 Annual Meeting.

#### OSMA Gains Corrective Amendments

Representatives of OSMA were able to obtain corrective amendments to Am. Sub. H. B. 417, a bill which provides for two advisory councils, one to make recommendations relative to the Hill-Burton program and a separate advisory group to make recommendations with regard to the Mental Health Facilities Construction Act passed in the last session of Congress. The bill was subsequently passed and became effective on June 7, 1965.

Language in the original bill would have permitted the Director of Mental Hygiene and Correction to receive funds for the staffing (professional salaries) and operation of the facilities constructed with federal assistance. Other language in the bill would permit Ohio implementation of H. R. 2985, since passed by Congress, which is aimed at providing this staffing money.

Under the original Sub. H. B. 417, the director could have requested these staffing funds without the Ohio General Assembly's approval of the program anticipated under H. R. 2985. Also, he could have requested funds for any programs provided by current or future amendments to the federal mental health facilities construction legislation.

This would have meant that any program established under the federal law by the Congress in the

future could be set up in Ohio without legislative approval. OSMA's amendments eliminate this possibility.

#### Other Health Legislation

Various other bills, of interest to physicians, are listed below indicating the position of OSMA regarding the legislation and its fate in the General Assembly.

H. B. 5 — To eliminate "other assets" from consideration in determining support of patients in benevolent institutions. Approve in Principle. Passed, effective 10-26.

H. B. 45 and H. B. 147 — To require an identification emblem for certain types of slow moving vehicles. (OSMA Council voted on December 13, 1964 to support this type of legislation). Continue support. H. B. 45 indefinitely postponed; H. B. 147, Passed, effective April 1, 1966.

H. B. 62 — To permit electors admitted to a hospital under emergency conditions immediately prior to an election to obtain absent voters' ballots. No objection. Indefinitely postponed.

H. B. 73 — Relative to voting by permanently disabled voters; requires Doctor's certificate. No objection. Died in committee.

H. B. 84 — To permit payment of the state subsidy for specifically training of mentally deficient persons regardless of age of such persons. Approved. Passed; effective 8-26.

H. B. 92 and H. B. 142 — To establish an air pollution control board. Active support. H. B. 92 indefinitely postponed; H. B. 142 indefinitely postponed.

H. B. 99 — To require seat belt assemblies in all cars sold in Ohio that are manufactured after January 1, 1966. (OSMA Council approved support of this type legislation September 19-20). Continue support. (Also approved requirement for rear seat belts). Indefinitely postponed.

H. B. 108 — To permit the admission of testimony by means of deposition of physicians who reside within the county in which the suit is being tried. (Passed House week of February 25, 72-56). Active support. Passed, effective 9-28.

H. B. 121 — Relative to the operation of motor vehicles while under the influence of alcohol: "Implied consent" bill. (OSMA Council on July 25, 1964 approved support of this type of legislation in principle. Indefinitely postponed.

H. B. 133 — To prohibit the advertising of dangerous drugs to the public. (OSMA House of Delegates determined at its 1964 session that OSMA should actively support this type of legislation.) Defeated in House, 59-64.

H. B. 173 — This bill would increase the minimum population to constitute a city health district from the

present 5,000 to 25,000. Smaller cities having health districts could keep them until January 1, 1968. Reaffirm support. **Defeated in House, 56-71.**

**Am. H. B. 218** — To require municipal or county peace officers receiving from a physician a report of possible child abuse to refer such report to the county welfare department or child welfare board for investigation, was heard before the House. Amended House Bill was passed. Approve in principle. **Passed.**

**H. B. 247** — To enable recipients of public assistance to retain earnings within minimum assistance standards. No objection. **Passed, effective 9-6-65.**

**H. B. 257** — Define "coroner" and require funeral directors to report suspicious deaths to the coroner immediately. Also changes wording from "hold an inquest" to "make inquiry." No objection. **Passed.**

**H. B. 413** — Require motor vehicles, after January 1, 1967 to be equipped with air pollution control devices. Approve. **Indefinitely postponed.**

**H. B. 439** — To amend section to provide for the tolling of the statute of limitations for disabilities arising after the accrual of the cause of action. Oppose. **Corrective amendments obtained by OSMA. Passed, effective 10-30-65.**

**H. B. 457** — Permits vacancy in director of local mental health clinics to be filled on a consultant basis. Approve in principle. **Passed, effective 6-26-65.**

**H. B. 569** — To prohibit driving while under the influence of barbiturates. Oppose. **Indefinitely postponed.**

**S. B. 7** — To require the installation of seat safety belt assemblies in all cars registered in Ohio which are manufactured after January 1, 1966. (OSMA Council approved support of this type legislation at the September 19-20 meeting.) Continue support. (Also approved requirement for rear seat belts). **Passed, effective 8-9-65.**

**S. B. 108** — Relative to the creation of an advisory board to the state board of cosmetology, membership of the state board of cosmetology, and the licensing of cosmetologists, managing cosmetologists, instructors, and manicurists. Oppose elimination of physician from board. **Physician reinstated at OSMA insistence. Passed, effective 10-15-65.**

**S. B. 142** — To reduce Ohio personal property taxes, has been introduced and referred to the Senate Taxation Committee for hearing. Under terms of the bill, property now assessed at 70 per cent would be reduced three per cent per year for ten years, ultimately reaching 40 per cent. This approaches the percentage at which real property is generally assessed. Support. **Indefinitely postponed.**

**S. B. 153** — To include blood type, any requirement for insulin, and a photograph, on all drivers licenses, has been introduced and referred to Senate

Committee on Highways and Motor Vehicles. Oppose. **Died in committee.**

**S. B. 157** — To remove relatives liability for support of patients in mental hospitals or benevolent institutions under the control of the Department of Mental Hygiene and Correction, has been introduced and referred to the Senate Committee on State Government. Oppose. **Died in committee.**

**S. B. 165** — To also restrict driver licenses to be granted under certain conditions to a person who has been adjudged mentally ill. Oppose. **Died in committee.**

**H. B. 728** (Messrs. Albritton-Landes-McNamara-Riffe-Mooney), to create a department of mental health and a department of correction. (Approve if medical qualifications for director of mental health are established.) **Died in committee.**

**H. B. 734** (Reilly), to repeal the law establishing a board of review to hear grievances arising from licensing board actions. (Approve.) **Defeated in House 59-51. (No majority.)**

**H. B. 738** (Valiquette), to provide that all shot (ammunition) sold in Ohio have a steel base or be so composed as to permit removal by magnets in medical operations. (Oppose.) **Indefinitely postponed.**

**H. B. 767** (Horvath), to create a state board of hospitalization. (Vigorously oppose.) **Indefinitely postponed.**

**H. B. 861** (Weisenborn - Gindlesberger), deletes grandfather clause from requirement that coroners be physicians. (Support.) **Passed.**

**H. B. 862**, provides a state board of nursing to regulate practice of nursing. (Oppose.) **Died in committee.**

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### **AMA Publication, "New Drugs" Now in Second Printing**

More than 17,000 copies of *New Drugs: 1965* had been sold by early August to physicians and other medical personnel, the American Medical Association announced. The book is now in its second printing.

Distribution of the book began in June. The six-month sales figures exceed the total average of 13,000 to 14,000 annual sales of *New and Nonofficial Drugs*, an older AMA annual publication which was replaced by *New Drugs*.

Orders for the book may be placed with the American Medical Association, Chicago. The AMA sells the volume at cost: five dollars per copy, or four dollars per copy if the purchaser is a house officer or medical student.

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Dr. Samuel A. Saslaw, professor of medicine in the Ohio State University College of Medicine, has been awarded a renewal grant of \$26,347 by the U.S. Public Health Service to continue investigation of relationship between the spleen and infection.



# AMA Clinical Convention . . .

Convenient for Attendance by Ohio Physicians, Sessions  
Will Be Held in Philadelphia, November 28 - December 1

A COMPREHENSIVE scientific program, a new postgraduate course, and special clinical workshops are some of the features of the American Medical Association's 19th Clinical Convention, November 28 - December 1, in Philadelphia.

More than 300 physicians will participate in giving the four-day program of lectures, exhibits, motion pictures, color television, fireside conferences, and breakfast roundtables.

An outstanding scientific program is designed to hold special interest for the practitioner. Some topics to be covered: Ulcerative colitis, gram-negative bacterial infections, a medical-surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

The practicing physician will be able to participate in one of the convention's new features. Clinical workshops on diabetes, examination of the heart, management of common eye problems, and the solution of selected diagnostic and therapeutic problems will be conducted by outstanding teachers.

Also new will be a postgraduate course in cardiovascular therapeutics. It will be offered in addition to the popular course on gynecology and obstetrics begun at the clinical convention last year in Miami.

The annual AMA conference on the Medical Aspects of Sports will be held the first day of the meeting, November 28, in the Benjamin Franklin Hotel. It will be of special interest to high school and college team physicians.

There will be approximately 100 scientific exhibits, and 30 medical motion pictures.

Color television will be presented on the stage of the Civic Center in cooperation with the Hospital of the University of Pennsylvania. The subjects of six programs, to be followed by discussion, are "Lymphocytes, Cellular Immunities and Tissue Transplantation," "Renal Hypertension," "Pulmonary Resection," "Pulmonary Function Studies," "Surgical Aspects of Thyroid Diseases," and "Medical Aspects of Thyroid Diseases."

Twelve fireside conferences will be held Sunday evening, November 28, at the Warwick Hotel. They will be joint sessions of the American College of Chest Physicians and the AMA.

W. Emory Burnett, M. D., is general chairman of the meeting. Donald A. Dupler, M. D., is chairman of the scientific program committee.

## Sports Conference

Management of head, neck and knee injuries will be among the main topics at the Seventh National

Conference on the Medical Aspects of Sports, Sunday, November 28, in Philadelphia.

The day-long conference will be in conjunction with the AMA clinical convention. The conference promises to be of wide interest to physicians, especially those serving as high school or college team physicians.

Other featured topics: weight control in wrestling, estimation of the athlete's readiness for sports, and help for the atypical athlete in finding a place in sports.

Knee injuries, the most prevalent type in athletics, will get their due attention in evening sessions. Particular emphasis will be given to knee ligament injuries.

## Medical Education Anniversary

The 200th anniversary of medical education in the United States is being observed in Philadelphia as the American Medical Association holds its 19th Clinical Convention there November 28 - December 1.

The convention is being held in cooperation with the bi-centennial observance of the nation's oldest medical school, the University of Pennsylvania School of Medicine.

Physicians and their families will be able to participate in ceremonies observing the school's founding. They also will have opportunities to visit other parts of historic Philadelphia.

Independence Hall, the Liberty Bell, Betsy Ross' house and the old Custom House are among many important historical sites that make Philadelphia one of America's most interesting cities to visit.

Philadelphia has many luxurious hotels and colorful restaurants. Blocks of rooms in ten major hotels have been reserved for those attending the convention.

For more information on registration, write to Circulation and Records Department, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

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"Medical Staff in Action — 1965, The Utilization Committee," will be the theme of the seventh annual Conference on Medical Services to be held Saturday, November 27, 1965, in Philadelphia, the American Medical Association has announced.

Sponsored by the AMA's Council on Medical Service and its Committee on Medical Facilities, the one-day meeting will be held in the Bellevue Stratford Hotel and will immediately precede the AMA's 19th Clinical Convention.

# Outstanding Scientific Exhibits At OSMA Annual Meeting

AT the 1965 Annual Meeting of the Ohio State Medical Association held in Columbus, 34 Scientific and Educational Exhibits were presented and drew an unusual amount of interest from physicians. As previously recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for a limited number of exhibits designated as outstanding by the judging committee. This year six exhibits were selected to receive the special honors which included mounted and engraved plaques, certificates and monetary awards. The committee designated three exhibits in the field of teaching and three in the field of original investigation to receive respectively the gold, silver and bronze awards. Following are brief descriptions of two of these outstanding exhibits with photographs on the facing page:

\* \* \*

## Pheochromocytoma Exhibit Wins Silver Award in Teaching

Silver Award winner in the field of teaching at the 1965 OSMA Annual Meeting was the exhibit entitled "Pheochromocytoma — Diagnosis and Management," sponsored by Dr. John H. Wulsin, and Dr. Thomas E. Gaffney, of the University of Cincinnati College of Medicine.

The first panel of the exhibit described the signs and symptoms suggestive of these endocrine tumors and the approximate incidence among patients.

The center panel presented a summary of the types of chemical tests available for the diagnosis and localization of the tumor. In particular, the chemical tests and their relative values for screening and confirmation of the diagnosis was presented. Tests included the measurement of norepinephrine, epinephrine, metanephrines, and vanilmandelic acid. The measurement of blood catecholamines as a maneuver to assist in the localization of the tumor also was described.

The third panel demonstrated important stages in the approach and operative management of pheochromocytoma. Supportive measures including anesthetic, pharmacologic control, and fluid and electrolytes also were listed.

An invitation has been issued by the University of Cincinnati Medical Center for physicians of the community to use the special diagnostic facilities at Cincinnati General Hospital and to call upon scientists there to aid in detecting pheochromocytoma. The physicians involved in the program are already performing tests on request of local physicians and with present facilities the services can be increased.

## Lumbar Discography Exhibit Receives Silver Award

Winner of the Silver Award in the field of original investigation was the exhibit, "Lumbar Discography; A Twelve Year Experience," sponsored by the team from the Cleveland Clinic Foundation consisting of Dr. John S. Collis, general practitioner, Dr. W. James Gardner, neurosurgeon, and Dr. Thomas Tank, surgeon.

This diagnostic procedure for visualizing the lumbar disks has been used by the authors for more than 12 years. The physician observer at the booth was given a graphic analysis of some 3,000 consecutive discograms recorded during that period.

An observer at the exhibit was first given illustrations of the technique of lumbar discography. In the second panel, roentgenograms and schematic drawings illustrated the three diagnostic types of lumbar discograms.

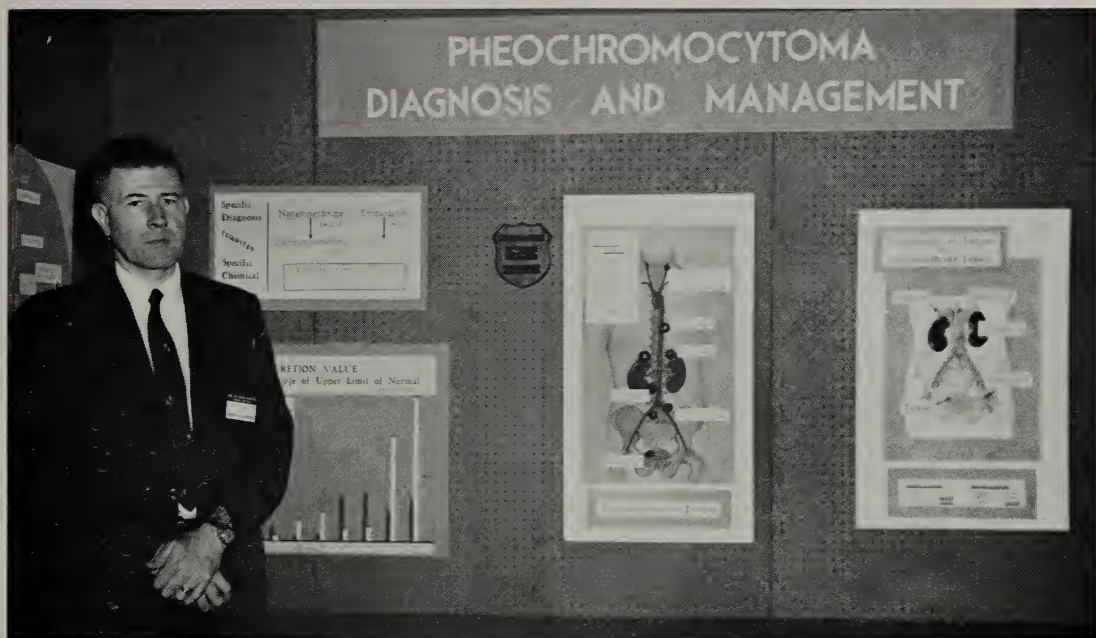
The third panel in the display compared lumbar discography with pantopaque myelography. The fourth panel in the exhibit gave the authors' conclusions based on experiences gained from the 3,000 odd discograms recorded during the period of investigation.

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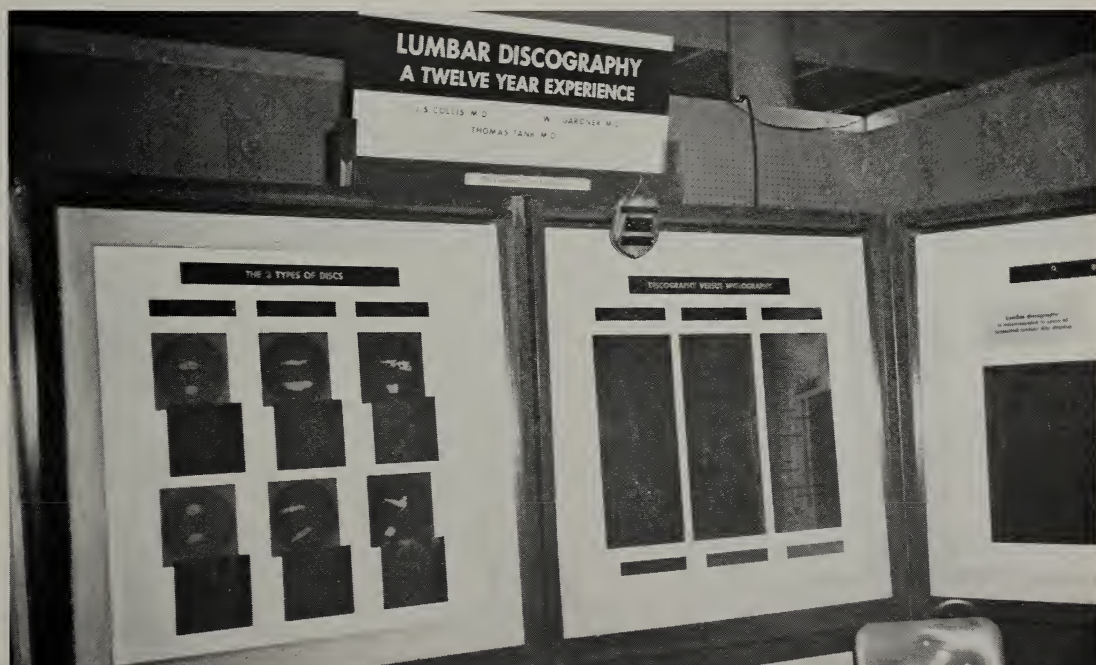
Refer also to the August issue of *The Journal*, pages 754-755 for additional outstanding exhibits presented at the OSMA Annual Meeting. Additional information on other exhibits will be presented in a coming issue of *The Journal*.



# Silver Award Winning Exhibits



*This is the Silver Award winning exhibit in the field of teaching entitled, "Pheochromocytoma—Diagnosis and Management," as it was shown at the 1965 OSMA Annual Meeting in Columbus. Shown manning the exhibit is Dr. Irvin B. Hanenson, who is taking an active part in the Cincinnati project.*



*This exhibit, entitled "Lumbar Discography—A Twelve Year Experience," won the Silver Award in the field of original investigation at the 1965 OSMA Annual Meeting. It was sponsored by a team from the Cleveland Clinic Foundation.*

# Ohio Fall Postgraduate Programs . . .

## A Number of Additional Programs Are Added To List Of District and Other Group Meetings in This State

**I**N the following columns are a number of additional programs scheduled in Ohio this Fall and announced after the September issue of *The Journal* had gone to press; also programs previously printed, but in some cases with additional information.

Ohio physicians will find in this listing numerous programs within easy traveling distances from their homes, with an unusual array of talented speakers and subjects of practical value from the standpoint of everyday practice.

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### Announce First Ohio Congress On Psychological Medicine

The Ohio State Medical Association's Committee on Mental Health is sponsoring the First Ohio Congress on Psychological Medicine to be held at the Sheraton-Columbus Motor Hotel, Third and Gay Streets, in downtown Columbus, Sunday, October 24.

Cosponsors are the Ohio Psychiatric Association, Ohio Academy of General Practice, Ohio Chapter of the American Academy of Pediatrics, Ohio Society of Internal Medicine and the OSMA Section on Obstetrics and Gynecology.

Registration opens at 8:00 a.m. with the first program feature at 9:00 o'clock. Fee is \$10 which includes luncheon.

Reservations should be made with the Ohio State Medical Association, 79 E. State Street, Columbus, Ohio 43215 by October 15.

Refer to September issue of *The Journal*, pages 842-843 for complete program and reservation form.

\* \* \*

### Lectures on Human Reproduction Scheduled in Cleveland

The Institute for the Study of Human Reproduction, in association with the Saint Ann Hospital, Cleveland, presents "New Horizons in Reproductive Physiology and Pathology Lecture Series No. 4," November 8-10, in the building of the Academy of Medicine of Cleveland, 10525 Carnegie Ave.

Moderator: Dr. Ralph M. Wynn, assistant professor of obstetrics and gynecology, State University of New York.

Monday, November 8 — Dr. John McLean Morris, professor of obstetrics and gynecology, Yale Univer-

sity School of Medicine; 5:00 p.m., "Ovarian Tumors"; 8:00 p.m., "Intersexuality."

Tuesday, November 9 — Dr. Harry Prystowsky, professor and chairman, Department of Obstetrics and Gynecology, University of Florida College of Medicine; 5:00 p.m., "Mount Everest in Utero"; 8:00 p.m., "Studies Relating to Anaerobic Metabolism in Human Pregnancy."

Wednesday, November 10 — Dr. Melvin L. Taylor, Peter Bent Brigham Hospital and Harvard Medical School; 5:00 p.m., "Gonadotrophins in Infertility"; 8:00 p.m., "Mechanism of Action of Synthetic Steroids."

Physicians interested in these and other courses offered by the institute are invited to contact Joseph Thomas Velardo, Ph.D., Director, Institute for the Study of Human Reproduction, Postgraduate Education Division, 2475 East Blvd., Cleveland, Ohio 44120.

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### Program on Diabetes Is Among Courses Offered at OSU

A short course entitled, "Diabetes Mellitus: Past, Present, Future," is among postgraduate courses offered by the Ohio State University College of Medicine, this one cosponsored by the Central Ohio Diabetes Association, on Thursday, October 14.

Registration opens at 8:15 a.m. with the first program feature at 9:15 a.m. in the Ohio Union, 1739 N. High Street, Columbus.

Among program features are the following:

**Metabolic Homeostasis — Carbohydrate, Lipid, and Protein Interrelationships**, Dr. Fred A. Kruger, associate professor of medicine and professor of physiological chemistry; director, Clinical Research Center Laboratories, OSU.

**Insulin and Insulin Antagonists** — Dr. George Cahill, Harvard Medical School, director of the Joslin Clinic Research Center, Boston.

**Rats, Indians, and Diabetes**, Dr. Max Miller, associate professor of medicine, Western Reserve University Hospitals, Cleveland.

**What Is Diabetes?** Dr. William Daughaday, associate professor of medicine, Washington University, St. Louis.

**Acidosis and Coma in Diabetes — Ketotic and Non-Ketotic** — Dr. Thaddeus S. Danowski, professor

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and chief of the Section on Endocrinology and Metabolism, University of Pittsburgh School of Medicine.

**Pharmacological Agents (Hypoglycemic and Diabetogenic),** Dr. George J. Hamwi, professor and director of the Division of Endocrinology and Metabolism, OSU.

Panel Discussion, moderated by Dr. Hamwi.

Dr. James V. Warren, chief of the Department of Medicine at OSU, will open the program session. Dr. Richard Fulton, Columbus, will preside as moderator during the luncheon.

A program for the lay group will be sponsored by the Central Ohio Diabetes Association at 8:15 p. m. at the Columbus Gallery of Fine Arts.

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Other postgraduate courses offered at Ohio State University in the near future include the following:

October 6 — Tenth Annual Session on Rheumatic Diseases.

October 8 - 9 — Headache, Backache and Intractable Pain.

October 20 — Pediatric Invitational Clinic.

October 29 - 30 — Second Annual Ob-Gyn Endocrine Seminar.

November 1 - 24 — Neuropsychiatry Board Refresher Course.

November 3 — Emergency Care of Common Hand Injuries for the Family Physician.

November 4 — Multiple Sclerosis Clinic Day.

November 7 - 9 — Medical Education Seminar.

December 2 - 3 — Psychiatry Seminar.

Additional information on the foregoing or other courses may be obtained from The Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. Tenth Ave., Columbus 43210.

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## Columbus Academy Announces Specialty Day Program

Dr. Peter H. Knapp, professor of psychiatry, Boston University School of Medicine, will be guest speaker for the annual Specialty Day program on Monday, November 15, presented by the Academy of Medicine of Columbus and Franklin County and specialty societies of the area.

Cosponsors of the program dealing with emotional aspects in treatment of the patient are the Columbus Ob-Gyn Society, the Neuropsychiatric Society of Central Ohio, and the Central Ohio Academy of General Practice.

Physicians outside of Franklin County who are interested in attending this program are invited to contact the Academy for arrangements.

## Metropolitan Areas and Medical Postgraduate Programs

The accompanying summary of postgraduate programs is presented in an effort to bring together sessions of particular district-wide interest. Many more postgraduate programs are available, particularly in the metropolitan areas. Physicians are invited to contact Academies of Medicine and Specialty Societies in these areas as well as the Medical Teaching Centers for lists of programs scheduled.

## Change in Date Announced for Northwestern Ohio Program

The Northwestern Ohio Medical Association has announced a change in date for its annual program scheduled at the Findlay Country Club, Findlay. The new date is November 11. The organization consists of physicians of the Third and Fourth Councilor Districts.

A team of physicians from the Cleveland Clinic Foundation will present a program dealing with practical gastroenterology. Physicians of the districts will receive a program by mail. Others who wish information are invited to contact Dr. Loren E. Senn, 1400 South Main Street, Findlay.

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## District V Ob-Gyn Program Scheduled in Cleveland

District V of the American College of Obstetricians and Gynecologists is holding its annual meeting in Cleveland, Thursday-Saturday, October 28-30.

The physicians, who meet at the Statler-Hilton Hotel, open their sessions with an all-day postgraduate conference on the kidney, to be presented by the Staff of the Cleveland Clinic in cooperation with the College.

An associated Conference for Nurses will be held at the Sheraton-Cleveland Hotel on the same dates. Registration at either hotel meeting is open to all interested persons.

Eduard Eichner, M.D., 10605 Chester Avenue, Cleveland, is chairman of the Ohio Section, ACOG.

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## Neurology Seminar Is Offered At St. Vincent Hospital

St. Vincent Charity Hospital, 2222 Central Avenue, Cleveland, is offering a Neurology Seminar on Wednesday, October 27, beginning at 9:00 a.m. and concluding with a social hour, dinner and an address by an after-dinner speaker. All interested physicians

(Continued on Next Page)

are invited, especially those in the northeastern area of Ohio.

Registration should be made not later than October 15 with the Registrar, St. Vincent Charity Hospital at the foregoing address. Fee for the course, including luncheon, is \$15.00; with an additional \$5.00 for the social hour and dinner.

Master of ceremonies will be Frank R. Hanrahan, M. D., director of medicine for St. Vincent Hospital. After dinner speaker will be Joseph M. Foley, M. D., professor of neurology, Western Reserve University.

The complete program for the St. Vincent Charity Hospital Neurology Seminar will be found on page 935 of this issue, with other details about the meeting.

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## Disaster Hospital Training Program Columbus, October 17

A training program on the operation of Packaged Disaster Hospitals is planned for Sunday, October 17, 1965 at the Arts and Crafts Building and Building 55, Ohio Exposition Grounds, 600 East Seventeenth Avenue, Columbus.

This program will be sponsored by the Ohio State Medical Association Committee on Disaster Medical Care in cooperation with the Health Mobilization Unit, Ohio Department of Health.

The conference is designed to train physicians and others interested in being instructors in the operation of the Packaged Disaster Hospital. The instructors trained in this conference will conduct programs in Cincinnati, Columbus and Cleveland aimed at training a team of persons from each community where a Packaged Disaster Hospital is stored so that they will be able to operate that hospital.

There is no charge for registration. To register, please contact: Mr. W. Michael Traphagan, Secretary, Committee on Disaster Medical Care, Ohio State Medical Association, 79 East State Street, Room 1005, Columbus. The program for the conference is listed below:

### Arts and Crafts Building

9:00 - 9:30 a. m.	Registration and Welcome
10:00	Management of Mass Casualties
10:30	Packaged Disaster Hospital
11:00	Film "Packaged Disaster Hospital"
11:30	Utilization of the Packaged Disaster Hospital
12:00	Lunch
	Building 55

1:00 p. m. Functional Section Orientation.  
(Participants will be divided into sev-

(Continued in Next Column)

en groups and will rotate every 20 minutes through all seven sections.)

1. **Admitting and Triage**, Thomas W. Morgan, M. D., Gallipolis
2. **Ward**, N. J. M. Klotz, M. D., Wadsworth
3. **Operating**, Robert S. Heidt, M. D., Cincinnati
4. **Central Supply**, Elden C. Weckesser, M. D., Cleveland
5. **X-Ray**, Thomas D. Allison, M. D., Lima
6. **Laboratory and Pharmacy**, Nino M. Camardese, M. D., Norwalk
7. **Generator and Water Tank**, Wendell A. Butcher, M. D., Columbus

### Arts and Crafts Building

- 3:20 Organizing a PDH Training Program
- 3:40 Discussion and Adjournment

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## Sixth District Postgraduate Day In Canton on October 20

The Sixth Councilor District Postgraduate Day will be held in Canton at the Hotel Onesto on Wednesday, October 20, with registration open at 8:00 a. m. and the program beginning at 9 o'clock. Theme for the program is "What's New in the Practice of Medicine?"

Evening banquet speaker will be Tom Andrews, leading journalist, editorialist, syndicated columnist and worldwide speaker, Dr. A. R. Furnas, 420 Lake Avenue, N. E., Massillon, is Postgraduate Day chairman. Host organization is the Stark County Medical Society, with headquarters at 405 Fourth Street, N. W., Canton.

The program has been announced as follows:

### Morning Program

**Metabolic Aspects of Acute Infections**, Dr. William R. Beisel, Lt. Col. U. S. Army Medical Corps.

**Congenital Orthopedic Anomalies**, Dr. Frederick Rheinlander, associate professor of orthopedics, Western Reserve University.

**Modern Operation of an Industrial Medical Program**, Dr. John MacIver, assistant medical director, U. S. Steel Corporation.

**Radioactive Scanning and Echoencephalography**, Dr. G. Robert Nugent, associate professor of surgery, West Virginia University.

**Laser Surgery and Research**, Dr. K. W. Kitzmiller, Laser Laboratory, Children's Hospital, University of Cincinnati Medical Center.

**Cardio-angiography**, Dr. William C. Sheldon, Department of Pediatric Cardiology, Cleveland Clinic.

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*(Sixth District — Contd.)*

Panel: **Threatened Abortion — Its Cause, Management, and Prevention**, Dr. William C. Weir, Dr. Richard Stander, and Dr. William Rigsby.

**Practical Ways to Help the Infertile Patient to Motherhood**, Dr. William Weir, assistant clinical professor, Western Reserve University.

#### Afternoon Program

**Medicare — New Aspects and Their Impact on the Practice of Medicine**, Dr. James Donges, Anderson, Indiana.

**Modern Forensic Medicine**, Dr. Lester Adelson, chief of forensic pathology, Western Reserve University.

**A New Look at Viral Immunizations**, Dr. Fred Heggie, Department of Pediatrics, Western Reserve University.

**Recent Advances in Rh Investigation**, Dr. Richard Stander, associate professor of obstetrics and gynecology, Indiana University School of Medicine.

**Induction of Labor — Why, When and How**, Dr. William Rigsby, assistant professor of obstetrics and gynecology, Ohio State University.

**Studies and Experimental Immunopathology**, Dr. Fred Germuth, director of laboratories, Aultman Hospital, Canton.

Panel: **Trauma**, Drs. Rheinlander, Beisel and Nugent.

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### Hematology Among Courses Offered By the Cleveland Clinic

The Cleveland Clinic Education Foundation is offering a course, entitled "Selected Topics in Hematology," to be presented on Wednesday and Thursday, October 13 and 14, in the Bunts Auditorium of the Education Building.

Additional information on this and other courses may be obtained by writing the Education Secretary, The Cleveland Clinic Education Foundation, 2020 East 93rd Street, Cleveland 44106.

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Among other courses offered by the Cleveland Clinic Educational Foundation in the near future is one entitled:

**Recent Advances in Medical Treatment**, scheduled on November 3 and 4.

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### Management of Gynecologic Cancer Symposium at Saint Luke's

Saint Luke's Hospital, Cleveland, Division of Obstetrics & Gynecology, will present a symposium, "Modern Trends in the Management of Gynecologic Cancer," in Saint Luke's Hospital during the afternoon and evening of Monday, November 29.

*(Continued in Next Column)*

*(St. Luke's — Contd.)*

Two distinguished speakers, Professor H. L. Kottmeier of the Radiumhemmet, Stockholm, Sweden, and Dr. David A. Boyes of the Cytology Institute and British Columbia Cancer Institute, Vancouver, Canada, will present papers, and a distinguished panel of Cleveland gynecologists will take part in a round-table discussion.

Professor Kottmeier is a world-famous authority on radiotherapy and particularly the treatment of cancer of the cervix. Dr. Boyes, a gynecologist and radiotherapist, is a well-known authority on mass cytology screening programs.

Following the afternoon meeting a reception and dinner will be held in Saint Luke's Hospital jointly sponsored by the Cleveland Society of Obstetricians & Gynecologists. Professor Kottmeier will be the featured speaker in the evening.

All interested physicians in the Northeast Ohio area are invited to attend.

Communications may be addressed to: Wendall W. Adams, M. D., Department of Obstetrics, Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland, Ohio 44104.

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### Eighth District Physicians To Meet in Lancaster

The Eighth Councilor District Annual Postgraduate Meeting will be held on Thursday, October 21, at the Lancaster Country Club, with the Fairfield County Medical Society as host.

Golf will be arranged on request by Jack Kraker, M. D. — green fee, \$4.00.

At 2:00 p. m. Earl K. Shirey, M. D., Cardiovascular Clinic, Cleveland Clinic, will speak on the topic, **Cinematography of Coronary Circulation and Valvular Lesions of the Heart**.

At 3:30 p. m. William A. Newton, Jr., M. D., Pathologist at Children's Hospital, Columbus, will speak on the topic, **Chemotherapy in Childhood Cancer**.

Cocktails and dinner with the ladies (\$4.50 per person).

At 8:00 p. m. Jerome F. Wiot, M. D., Associate Professor of Radiology, University of Cincinnati and Cincinnati General Hospital, will speak on the topic, **Extra-Cranial Vascular Disease — A Cause of Cerebral Vascular Insufficiency**.

The Woman's Auxiliary has arranged a program for the ladies. 1:30 p. m., Coffee at Mamaugh Memorial, East Main Street at High; 2:30, Style Show with Mrs. Martha Fieff, Washington, C. H., in charge; cocktails and dinner at the Lancaster Country Club; and 8:00 p. m., bridge.

Reservations should be arranged with George F. Jones, M. D., Program Chairman, Lancaster-Fairfield County Hospital, Lancaster.

# *Announcing: Institute On Voluntary Areawide Health Facility Planning*

Sheraton-Columbus Motor Hotel, Columbus

*Sunday, November 7, 1965*

*Sponsored by*

OHIO STATE MEDICAL ASSOCIATION

OHIO HOSPITAL ASSOCIATION

OHIO OSTEOPATHIC ASSOCIATION OF PHYSICIANS & SURGEONS

## PROGRAM

Registration and Coffee .....9:30 A.M. - 10:00 A.M.

Mezzanine

## MORNING SESSION

Mars Room

10:00 A.M. to 11:45 A.M.

Presiding: Henry A. Crawford, M.D., President  
Ohio State Medical Association

## Greetings:

James H. Moss, President, Ohio Hospital Association

Jack D. Hutchinson, D.O., President, Ohio  
Osteopathic Association of Physicians  
and Surgeons

Henry A. Crawford, M.D.

## "Why Voluntary Areawide Health Facility Planning?"

J. Everett McClenahan, M.D., Past-President,  
Allegheny County Medical Society,  
Pittsburgh, Pennsylvania

## Questions and Comments

## "The Physician's Responsibility in Areawide Health Facility Planning"

Homer A. Anderson, M.D., Past-President,  
Academy of Medicine of Columbus and  
Franklin County, Board Member, Columbus  
Hospital Federation

## Questions and Comments

## LUNCHEON

Venus Room 12:00 Noon

(Cost included in registration fee)

## AFTERNOON SESSION

Mars Room

1:30 P.M. to 3:30 P.M.

Presiding: Jack D. Hutchinson, D.O.

## "Progress and Problems of Areawide Health Facility Planning in Ohio"

Edward A. Lentz, Associate Director  
Ohio Hospital Association

## REACTOR PANEL

Moderator: Bernard J. Lachner, OHA Board Member  
Associate Dean, College of Medicine, Ohio State  
University

Delbert L. Pugh, Executive Director  
Columbus Hospital Federation

Charles W. Ingler,  
Director of Community Relations,  
National Cash Register Company,  
Dayton

David Ross, M.D., Executive Director  
Jewish Hospital, President, Greater Cincinnati  
Hospital Council

Frank F. A. Rawling, M.D., Member Board of  
Trustees, Hospital Planning Association of  
Greater Toledo

John R. Mannix, Director of Research, Blue Cross  
of Northeast Ohio, Cleveland

Emmett W. Arnold, M.D., Director  
Ohio Department of Health

Martin A. Janis, Director, Ohio Department of  
Mental Hygiene and Correction

## Questions and Comments

## "Areawide Planning — Voluntary or Else?"

The Very Rev. Msgr. John C. Staunton  
Board Member, Ohio Hospital Association

Adjournment.



PROGRAM: Institute on Voluntary Areawide Health Facility Planning  
PLACE: Sheraton-Columbus Motor Hotel (Mars Room)  
Third & Gay Streets  
TIME: 9:30 A. M. - 3:30 P. M. — November 7  
FEE: \$6.00 per person (Includes Lunch)

Registrant's Name .....  
(If more than one person, please list other)

Title.....

Address.....

Mail to:

OHIO HOSPITAL ASSOCIATION  
Room 501, 40 South Third Street  
Columbus, Ohio 43215

(Make check payable to Ohio Hospital Association)

Receipt of your application will be acknowledged, and a blank sent to you, should you desire to make hotel reservations. The telephone number at the Sheraton-Columbus Hotel is 228-6060.

### Major Medical Expense Insurance Is in Increasing Demand

Major medical expense insurance protected 47,001,000 Americans by the end of 1964, and benefits from this coverage amounted to \$942,528,000 for the year, the Health Insurance Institute reported.

Major medical was introduced 15 years ago by insurance companies to provide a high level of benefits for serious illness or injury.

Both in coverage and benefits, major medical registered record highs last year. Some 4,560,000 more persons (10.7 per cent) were protected under this insurance in 1964 than in 1963, and total benefits were \$129,778,000 higher.

The Institute noted that of the 151,123,000 persons with some form of health insurance in 1964, 31 per cent had major medical protection by insurance companies.

Major medical year-end coverage figures over the last decade and a half depict the increasing acceptance of major medical expense insurance and the role it plays in the personal economies of millions of American families, the Institute declared.

In 1951, 108,000 persons in the United States had major medical; by 1955, the total had risen to 5,241,000; and five years later, 1960, the total increased five-fold to 27,448,000.

### Drug Manufacturers Are Paying for Most of Their Own Research

The federal government, again in 1964, financed less than four per cent of company-conducted research in the drug field, the Pharmaceutical Manufacturers Association reported.

Research money spent within the industry during the calendar-year 1964 reached \$309.7 million, an increase of \$18 million over 1963. PMA said 59 companies reported spending \$298.1 million of their own funds on research and development during 1964. (In 1963, they spent \$282 million and expect to spend \$338.7 million in 1965.)

The federal government in 1964 financed \$11.5 million for drug research conducted by private companies. (In 1963, the U. S. financed \$9.7 million and expects to finance \$12.6 million in 1965, PMA said.)

Announcement has been made of the appointment of Dr. Robert Higgins Ebert, former Cleveland, as dean of the Harvard Medical School, effective July 1. Before leaving Cleveland to join the Harvard staff last year, Dr. Ebert was professor of medicine at Western Reserve University, chief of medicine at University Hospitals, and a board member of the Academy of Medicine of Cleveland.

# Community Mental Health Information For Ohio Physicians

A Statement by The Committee on Community Mental Health Services,  
Ohio Psychiatric Association, Donald H. Burk, M. D., Chairman

IT is generally recognized that most physicians spend a large percentage of their time treating patients whose problems are primarily psychogenic and not due to organic pathology. On the community level there is a growing interest in improving the care of the mentally ill in Ohio.

For both of these reasons, Ohio physicians may want a review of their role in the management of the mentally ill and those individuals with related personality dysfunctions including alcoholism and addiction. This role has two facets or levels, the individual and the community.

## Management of the Individual Patient

In the management of the individual patient, good treatment depends, first of all, on adequate diagnosis. The physician needs to know, for example, not only that the patient is anxious but why he is anxious. Is he a chronically anxious individual who might best be treated with mild tranquilizers on an out-patient basis? Or, is his anxiety due to a specific problem within his current life situation? Is it a symptom of a developing involutional psychotic reaction? Treatment of the anxious patient must be individualized.

The present therapeutic armamentarium for the treatment of the patient with psychogenic difficulties has several facets. Psychoactive drugs have been found during recent years to be very helpful in treatment of many cases. The chemotherapeutic prescription must be tailored to an adequate understanding of the individual patient and his needs. Psychotherapy and the relationship with the physician continue to be of paramount importance in the treatment of the patient with psychogenic difficulties. This aspect of treatment, too, is most effective when based on an adequate understanding of the patient.

The setting of treatment may be as important as the particular type of treatment. For many reasons some patients need to be hospitalized. Of these, some will do best in the psychiatric unit of the general hospital or, lacking a psychiatric unit, in the general hospital proper. Others may need the more long-range, intensive, and comprehensive treatment available only, or most commonly found, in the psychiatric hospital. Depending on the patient and the nature of his problem, much of his treatment might be delegated to various ancillary personnel, including the clinical psychologist, the psychiatric social worker, the psychiatric nurse, the adjunctive therapist, etc.

Some patients may be adequately treated in a day hospital in which they maintain their family contact

by spending the evening and night at home, reporting to the treatment center for therapy during the day. By contrast, the night hospital provides treatment in the evening or night and the patient continues his usual activities away from the hospital or treatment center during the day. Again, ancillary personnel and community agencies may play a very significant role in the treatment and/or rehabilitation of the individual patient. (It is not within the scope of this discussion to consider the indications and contraindications of the varieties of treatment or treatment settings.)

## Services on the Community Level

On a community level the services of a comprehensive treatment center should be conveniently available to every citizen. Such a center should provide facilities for emergency treatment and management of the acute psychiatric problem, both short and long-range inpatient treatment, day and night hospital facilities, outpatient facilities, consultation and public education services for community agencies and representatives from schools, courts, clergy, employers and potential employers of patients, social and vocational rehabilitation programs, training and research in psychiatry. In the future, federal funds may be available for staffing as well as building such treatment centers.

It falls to us as physicians to provide the leadership in the development of community mental health programs. If we do not do so, such programs may go ahead without effective medical advice and direction. The medical profession has always provided the best care and guidance, and mental health care must be no exception.

The Ohio Psychiatric Association and its membership stand ready to provide support and consultation wherever it is requested. The Ohio Psychiatric Association knows of the untapped sources of mental health manpower in the medical profession in Ohio and wants to see them utilized. Toward the end of better meeting the challenge of providing the best and most comprehensive care for Ohio's mentally ill, plans have been made for a Congress on Psychological Medicine in Ohio in the fall of 1965. The Ohio Psychiatric Association, through the efforts of the Committee on Community Mental Health Services, hopes to provide periodic information of value to Ohio physicians, which information will enable them to work more effectively with Ohio psychiatrists in the comprehensive community mental health movement.



APPLICATION FOR SPACE, SCIENTIFIC AND HEALTH EDUCATION  
EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 1966 ANNUAL MEETING,  
SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 24 - 28

1. Title of Exhibit: \_\_\_\_\_

2. Name(s) of Exhibitor(s): \_\_\_\_\_

Institution (if desired): \_\_\_\_\_

City \_\_\_\_\_

3. Do you have a built-in exhibit? \_\_\_\_\_

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

Charts and posters \_\_\_\_\_ Photographs \_\_\_\_\_ Drawings \_\_\_\_\_ X-rays \_\_\_\_\_  
Specimens \_\_\_\_\_ Moulages \_\_\_\_\_ Other material \_\_\_\_\_  
(Describe)

6. Booth Requirements:

Amount of wall space needed? \_\_\_\_\_

Back wall \_\_\_\_\_ Side walls \_\_\_\_\_

Square feet needed? \_\_\_\_\_

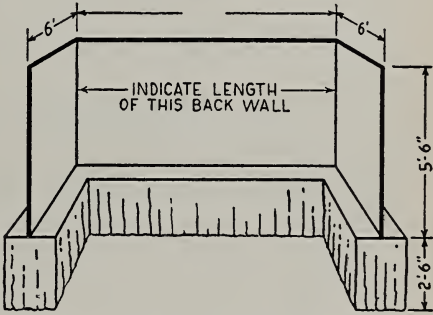
Shelf desired? (yes or no) \_\_\_\_\_

7. Transparency Cases:

Needed? (yes or no) \_\_\_\_\_

If answer "yes," give following information:

Number of transparencies to be shown and size of each \_\_\_\_\_



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date \_\_\_\_\_

Signature of Applicant

Mailing Address, Street

City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND HEALTH EDUCATION EXHIBITS,  
OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS, OHIO 43215  
DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1966

# Ohio's Executive Secretaries Attend Unique Conference

A NEW phase in the interrelationship between medical organization work on the county, state and national levels was put into effect when Ohio's County Medical Society Executive Secretaries met in Chicago on August 17. The meeting, held in the Board Room of the American Medical Association, was attended by two elected officers of the Ohio State Medical Association, the entire OSMA executive staff, 14 persons from the staffs of county medical organizations, plus a number of persons from the AMA headquarters.

Sponsored by the OSMA, part of the expenses of county executive secretaries was paid by the Association upon approval of The Council. Arrangements in Chicago were made by the Field Service Division of the AMA.

AMA officials expressed enthusiasm for results of the meeting, the first of its kind ever held in association with national meetings. Persons attending the Ohio conference also attended the Medical Society Executives' Association Seventh Annual Institute held on August 18, and the AMA Public Relations Institute held on August 19 and 20, both in Chicago.

The meeting at AMA headquarters, 535 N. Dearborn Street, gave executive secretaries an opportunity to get better acquainted with workings of the AMA and to learn more about its many activities. Later in the week a tour of the headquarters building was arranged.

Dr. F. J. L. Blasingame, Executive Vice-President of the AMA, discussed in detail the workings of the AMA and the various problems facing medicine, particularly from the federal government standpoint.

Dr. Henry A. Crawford, OSMA President, and Dr. Lawrence C. Meredith, OSMA President-Elect, both attended the Ohio conference and took part in discussions. They also attended the other meetings in Chicago.

Staff members from county medical societies in Ohio who attended were: Charles G. Greig, Executive Secretary, Butler County Medical Society; W. "Bill" Webb, Executive Secretary, Academy of Medicine of Columbus and Franklin County, who presided; Edward F. Willenborg, Executive Secretary, Academy of Medicine of Cincinnati; Mrs. Gladys Davidson, Executive Secretary, Lorain County Medical Society; Robert W. Elwell, Executive Secretary, Academy of Medicine of Toledo and Lucas County; Howard C. Rempes, Executive Secretary, Mahoning County Medical Society; Robert F. Freeman, Executive Secretary, and Earl Shelton, Associate Executive Secretary, Montgomery County Medical Society;

J. H. Austin, Executive Secretary, Stark County Medical Society; Sidney H. Mountcastle, Executive Secretary, Summit County Medical Society, who was accompanied by his son Dan; A. Dana Whipple, Executive Secretary, Medina County Medical Society; Mrs. Patsy Askins, Executive Secretary, Sandusky County Medical Society; Mrs. Marge McLaren, Executive Secretary, Lake County Medical Society. Kenneth Evans, Executive Secretary of the Columbus Bureau of Medical Economics also was present, as was James Imboden, Columbus, regional executive secretary of the American Political Action Committee.

From the OSMA staff were Hart F. Page, Executive Secretary; Charles W. Edgar, Director of Public Relations; Herbert E. Gillen, Administrative Assistant; W. Michael Traphagan, Administrative Assistant; and R. Gordon Moore, Executive Editor of *The Journal*.

Other key persons in the AMA staff who discussed various phases of medical organization work at the Ohio conference included: Aubrey D. Gates, Director; William Ramsey, Assistant Director; Harry Hinton, and David B. Weihaupt, of the Field Service Division; Richard Bergen, LL.B., Secretary of the Committee on Medicolegal Problems; Dr. Bryan Fenton, Secretary of the AMA Committee on Federal Medical Services; Thomas Laughlin, Socio-Economic Activities Division; and Dr. Howard Doan, Department of Hospitals and Medical Facilities.

Fritz Fagler, Executive Secretary of the Allegheny County Medical Society, Pennsylvania, was a visitor at the conference.

## VA Psychiatric Patient Load Reverses 1949 Prediction

In 1949, 55,000 psychiatric patients were being cared for by the Veterans Administration and conservative projections of the trend at that time indicated a future psychiatric load of 122,000 by 1965.

Presently, the VA finds itself treating 54,900—500 less than the 1949 figure and 70,000 less than the expected increase.

Playing an important part in this new trend are the various services now available for rehabilitation of the mentally ill, such as the VA's program of pre-hospital and post-hospital care.

Ability of the agency's hospitals to shorten the period of stay, and thus care for double the number of veterans, has been aided by the rapid growth of such programs, improved medical staffing, and increased efficiency in the hospitals.—VA News Release.



# NEUROLOGY SEMINAR

## St. Vincent Charity Hospital

Cleveland, Ohio

Wednesday, October 27, 1965

- 9:00 a.m. The Neurology of the Physical Examination  
Simon Horenstein, M. D.  
Western Reserve University
- 9:45 The Neurology of Congenital Heart Disease  
Robert V. McMahon, M. D.  
St. Vincent Charity Hospital
- 10:10 Neurology of Renal Disease  
Thomas W. Wallace, M. D.  
Cleveland Clinic
- 10:30 The Neurology of Hypertension  
William J. Duhigg, M. D.  
St. Vincent Charity Hospital
- 11:00 Coffee
- 11:15 The Neurology of Pulmonary Disorders  
Fred Plum, M. D.  
Cornell University
- 11:45 The Neurology of Mental Retardation  
Robert Eiben, M. D.  
Western Reserve University
- 12:30 p.m. Panel Discussion  
Moderator  
John H. Gardner, M. D.  
Western Reserve University
- 1:00 Luncheon
- 2:00 Physiologic Mechanisms of Disordered Consciousness  
Fred Plum, M. D.  
Cornell University
- 3:15 Coffee
- 3:30 The Neurology of Virus Disease  
Richard J. Johnson, M. D.  
Western Reserve University
- 4:30 The Neurology of Liver Disease  
Maurice Victor, M. D.  
Western Reserve University
- 5:30 Cocktails  
Dinner

### Master of Ceremonies

Frank R. Hanrahan, M. D., Director of Medicine  
St. Vincent Charity Hospital

### Speaker

Joseph M. Foley, M. D., Professor of Neurology  
Western Reserve University

### Registration Fee:

\$15.00 Luncheon and Course  
5.00 Cocktails and Dinner

Make check payable to Registrar,  
St. Vincent Charity Hospital

2222 Central Ave., Cleveland, Ohio 44115

Reservations must be made by October 20.

## State Medical Board Issues

### Licenses to 334 M.D.'s

Examinations conducted by the State Medical Board of Ohio on June 17 - 19 were considered by the board at its meeting held on August 23, and the results announced by Dr. H. M. Platter, board secretary.

Certificates to practice medicine and surgery were awarded 334 graduates of schools of medicine, and 46 graduates of osteopathic schools were authorized certificates to practice osteopathic medicine and surgery. In addition, 23 chiroprodists (podiatrists) were authorized to receive certificates in their field of practice.

In the limited branches, four persons were awarded certificates to practice mechanotherapy, five to practice chiropractic, six to practice massage, five to practice cosmetic therapy and four to practice physical therapy.

The three highest grades in the examinations for doctors of medicine were made by graduates of Ohio State University College of Medicine. Larrie W. Greenberg, Toledo, averaged 89.2 per cent; Robert E. Stetson, Jr., Port Clinton, 88.9 per cent; and Owen E. Johnson, Columbus, 88.8 per cent.

## New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during August. List shows name of physician, county and city in which he is practicing or temporary addresses for those taking graduate work.

### Cuyahoga

Nejad Behzadi, Cleveland  
Richard E. Garcia, Cleveland  
James S. Jacobsohn, Cleveland  
Jack Kaufman, Cleveland  
James S. Marshall, Cleveland  
Pacifico C. Mercado, Cleveland  
James V. Scarella, Cleveland  
Maria B. Solymos, Cleveland

Leo T. Wagenbrenner,  
Columbus  
Robert A. Wehe,  
Reynoldsburg

### Lucas

Frederick C. Bowdle, Toledo  
Mortimer Hacker, Toledo

### Mahoning

Earl R. Ebie, Youngstown  
Clayton A. Hixson,  
Youngstown  
George T. Szaboky,  
Youngstown

### Montgomery

Herman M. Lubens, Dayton

### Summit

Carroll F. Boyles, Akron  
Salvador A. Duluc, Akron  
Henry M. Mobley, Akron  
Edward J. Shahady,  
Cuyahoga Falls

### Trumbull

Adolfo D. Games, Warren  
William G. McNally, Warren

### Franklin

J. Philip Ambuel, Columbus  
Sergio L. Cruz, Columbus  
J. Joanne Denko, Gahanna  
James W. Gahman, Columbus  
Armando A. Garzon, Columbus  
William R. Griffin, Jr.,  
Columbus  
Walter H. Hauser, Columbus  
Victor H. Hinrichs, Dublin  
Bulent Jajuli, Columbus  
Howard W. Marker, Columbus  
John L. Mormol, Columbus  
James S. McCaughan, Jr.,  
Columbus  
Richard S. Olson, Columbus  
Edward V. Quartetti,  
Columbus  
John P. Shultz, Columbus

## Ad Astra

**David Hannah Allen, M. D.**, Cincinnati; University of Cincinnati College of Medicine, 1927; aged 61; died July 22; member of the Ohio State Medical Association and former member of the American Medical Association. A former practitioner in Dover, Dr. Allen took special training at the University of Cincinnati and in recent years was staff psychiatrist at Longview State Hospital. His widow survives.

**Joseph W. Allman, M. D.**, Mt. Vernon; Ohio State University College of Medicine, 1944; aged 51; died August 23; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; past-president of the Knox County Medical Society. A practicing physician in the Knox County area for about 18 years, Dr. Allman was a veteran of World War II, having served in the Army Medical Corps. Among affiliations, he was a member of the Presbyterian Church. Survivors include his widow, two daughters and three sisters.

**Aretas E. Biddinger, M. D.**, Cleveland; Cleveland-Pulte Medical College, 1905; aged 84; died August 17; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice and the American Society of Abdominal Surgeons. A practicing obstetrician and surgeon of long standing in Cleveland, Dr. Biddinger was a veteran of World War I and a member of the American Legion. Other affiliations included memberships in several Masonic bodies, the Retired Officers Association and the Lions Club. His widow survives.

**Rolph M. Bone, M. D.**, Miami, Fla.; Western Reserve University School of Medicine, 1929; aged 61;

died on or about August 5 in Cleveland; former member of the Ohio State Medical Association and the American Medical Association. A practicing physician for a number of years in Cleveland and a lieutenant commander in the Navy Medical Corps during World War II, Dr. Bone retired in 1952 because of ill health. A son and a daughter survive.

**Kenneth D. Bryson, M. D.**, Olmstead Falls; New York University School of Medicine, 1910; aged 81; died August 29; former member of the Ohio State Medical Association. Dr. Bryson's practice in the Cleveland area extended over a long period and continued until a few days before his death. Survivors include his widow, a daughter and a brother.

**Samuel David Cohen, M. D.**, Coshocton and Riviera Beach, Fla.; Ohio State University College of Medicine, 1917; aged 73; died July 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Cohen practiced medicine in the Coshocton area from 1920 until his retirement in 1964. During World War I he served in the Army Medical Corps. Affiliations included membership in several Masonic bodies. Among survivors are his widow, a step-son; two grandchildren; two brothers and a sister.

**Marion Drexel Douglass, M. D.**, Cleveland; Johns Hopkins University School of Medicine, 1921; aged 69; died August 4; former member of the Ohio State Medical Association; diplomate of the American Board of Obstetrics and Gynecology. A former practicing physician in Cleveland and a member of the faculty at Western Reserve University, Dr.



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The effective sedative, hypnotic and anti-convulsant form of Chloral Hydrate.

Also Chlorasec for quick, even sleep. DriClor inner core (equivalent to 3.75 Grs. of Chloral Hydrate). Secobarbital acid outer coat (.75 Grs.)



Douglass was forced to retire in 1947 because of ill health.

**William E. Gallagher, M. D.,** Akron; University of Maryland School of Medicine, 1917; aged 79; died June 4; member of the Ohio State Medical Association and the American Medical Association. A native of Niagara Falls, Dr. Gallagher practiced medicine in Akron for some 35 years. He was a veteran of World War I. A member of the Catholic Church, he also was affiliated with the Knights of Columbus. Survivors include his widow, a daughter and a brother.

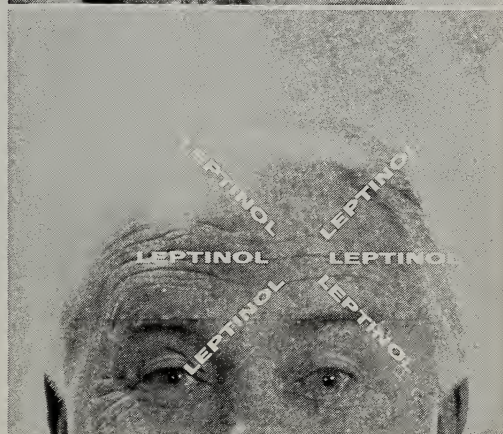
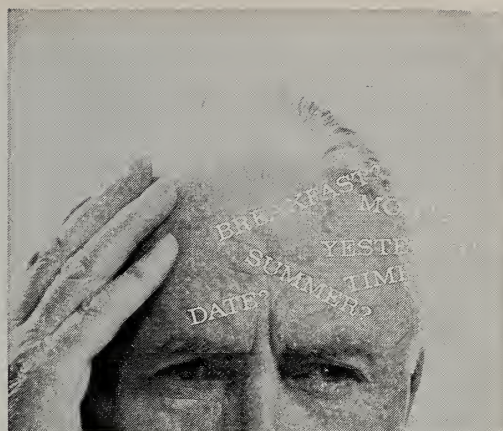
**Harry Goldblatt, Washington, D. C.;** Western Reserve University School of Medicine, 1955; aged 42; died August 29. A native of Cleveland, Dr. Goldblatt entered the Army Medical Corps in 1956 and was associated recently with the Walter Reed Army Institute of Research. Surviving are his widow, two sons, a daughter, his parents and a brother.

**Richard F. Grochocki, M. D.,** Cleveland; St. Louis University School of Medicine, 1956; aged 34; died August 24; member of the Ohio State Medical Association and the American Medical Association. A former resident of Cleveland, an honor graduate and winner of two fellowships in research, Dr. Grochocki returned to Cleveland five years ago to practice pediatrics and surgery. He was a member of the Presbyterian Church. Surviving are his widow, a daughter, his parents and four sisters.

**John E. Hannibal, Sr., M. D.,** Lakewood; St. Louis University School of Medicine, 1922; aged 68; died August 7; member of the Ohio State Medical Association, the American Medical Association and the International College of Surgeons; Fellow of the American College of Surgeons. Retired in recent years, Dr. Hannibal practiced for about 35 years in the Cleveland area and was closely associated with St. John Hospital. He was a member of the Catholic Church. Two physician sons also practice in Cleveland—Dr. Mark Hannibal and Dr. John E. Hannibal, Jr. Other survivors include his widow, a third son and a daughter.

**John A. Harold, M. D.,** Ottawa, Ohio; College of Physicians and Surgeons of Baltimore, 1903; aged 92; died August 13; former member of the Ohio State Medical Association. Dr. Harold moved to Putnam County and devoted a lifetime to practice in that area. He was a member of the Catholic Church, the Knights of Columbus, and a veteran of World War I. A daughter is among survivors.

**Joseph R. Johnson, M. D.,** Cleveland; Medical College of Alabama, 1930; aged 61; died August 24; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A practitioner for more than 35 years in the Cleveland area, Dr. Johnson's field was general practice and obstetrics. Active in community affairs, he was past-president of



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Non-addicting Leptinol also is valuable in long-term treatment, since patients do not establish a tolerance.

Each LEPTINOL bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE: one or two tablets, 3 times daily. Leptinol produces such a sense of well-being, patients should be cautioned not to exceed recommended dose which offers maximum effectiveness.

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*Caution should be taken when treating patients with a low convulsive threshold.*

*Write for detailed literature and starter Leptinol doses.*

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the area Kiwanis Club. Other affiliations included memberships in the Catholic Church and the Catholic Physicians Guild. He is survived by his widow, three sons, three daughters and a brother.

**Edward Sanford Kope, M. D.,** Akron; University of Michigan Medical School, 1936; aged 57; died June 17; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Akron for a number of years, Dr. Kope was in the military service during World War II. He was awarded several citations for services in the Asiatic-Pacific and the Philippine Liberation. Among survivors are a brother, and two sisters.

**Alexander F. McCoy, M. D.,** Columbus; Louisville National Medical College, 1911; aged 81; died August 15; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Columbus of long standing, Dr. McCoy specialized in the ear, nose and throat field. His numerous affiliations included memberships in the Baptist Church, the National Association for the Advancement of Colored People and the YMCA; also he was a 33rd Degree Mason. His widow survives.

**James I. Nisbet, M. D.,** Eaton; Ohio State University College of Medicine, 1915; aged 77; died August 25; member of the Ohio State Medical Association, the American Medical Association. A native of Preble County, Dr. Nisbet devoted a lifetime to practice in the Eaton area. He also devoted much of his time to medical organization work; was a past-president of the Preble County Medical Society and a delegate and alternate delegate to the OSMa for many terms. He also served on several committees of the State Association. During World War I, he served in the Army Medical Corps and from 1929 to 1940 he was Preble County health commissioner. Dr. Dick M. Nisbet, of Middletown, is his son. Also surviving are his widow, a daughter and a sister.

**Boni E. Petcoff, M. D.,** Toledo; Ohio State University College of Medicine, 1926; aged 65; died August 5; member of the Ohio State Medical Association and the American Medical Association. An earlier resident of Toledo, Dr. Petcoff returned there to practice after completing his medical training with honors and engaging in an outstanding athletic career. He was captain of the OSU Grid Team in 1923, was named all American football tackle, engaged in professional football while going through medical school, and won numerous other athletic honors. His practice in Toledo extended over some 38 years. Survivors include his widow, a brother, Dr. John Petcoff, also of Toledo, and a sister.

**John H. Selby, M. D.,** Alexandria, Va. (formerly of Akron); University of Pennsylvania School of Medicine, 1907; aged 87; died August 29; former member of the Ohio State Medical Association; past-president of the Summit County Medical Society. Dr. Selby was a practitioner in Akron in the 1920's and 1930's. Surviving are his widow, a son and a daughter.

**Russell N. Speckman, M. D.,** Cincinnati; University of Cincinnati College of Medicine, 1923; aged 70; died August 16; recent member of the Ohio State Medical Association and the American Medical Association. A practitioner of long standing in Cincinnati, Dr. Speckman was for many years on the faculty of the University of Cincinnati College of Medicine. His specialty was internal medicine with emphasis on cardiology. A brother survives.

**Louis P. Stickley, M. D.,** Cincinnati; University of Cincinnati College of Medicine, 1934; aged 56; died August 2; member of the Ohio State Medical Association, the American Medical Association and the American College of Cardiology. A practitioner in Cincinnati for most of his professional career, Dr. Stickley was a member of the faculty at the University of Cincinnati College of Medicine. His specialty was cardiology. Affiliated with the Catholic Church, he is survived by his widow, a daughter, two sons, a sister and two brothers.

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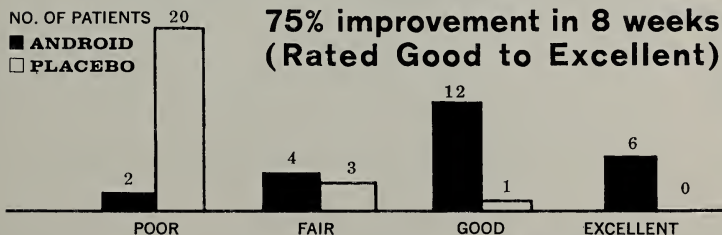
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3. *Thyroid-Androgen Relations*, L. Hellman, et al., *The Jrl. of Clin. Endocrinology and Metabolism*, August 1959.
4. Brochure *Discussing Thyroid-Androgen Interrelationship*.



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## Activities of County Medical Societies . . .

### BELMONT

The Belmont County Medical Society met with the Auxiliary at the Belmont Hills Country Club on September 16. The program centered around legal matters pertaining to organization.

### CUYAHOGA

The Academy of Medicine of Cleveland held its golf tournament on September 9 at the Hawthorne Country Club.

\* \* \*

"The Doctor's Role in a Changing Society" was the subject of a panel discussion on September 15 in the library of the John Carroll University. The Academy of Medicine of Cleveland and the university sponsored the program.

Dr. John H. Budd, Cleveland, presented the doctor's point of view, while Dr. John F. Sheehan, vice-president of Loyola University Medical Center at

Hines, Illinois, was moderator. Edward H. deConingh, president of the Cleveland Community Chest, discussed the doctor's role as the public sees it.

### FRANKLIN

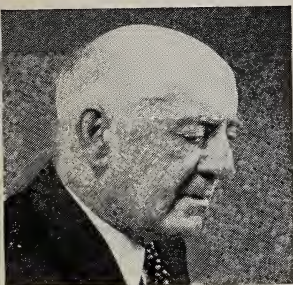
The Academy of Medicine of Columbus held its fifth annual golf outing on July 22 at the Ohio State University Scarlet Course, with social hour, dinner and business meeting at Stouffers University Inn.

Program speaker for the September 20 meeting of the Academy of Medicine of Columbus was Dr. Durward G. Hall, Congressman in the U. S. House of Representatives from the Seventh District of Missouri.

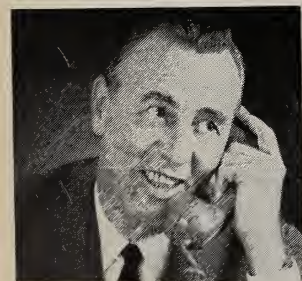
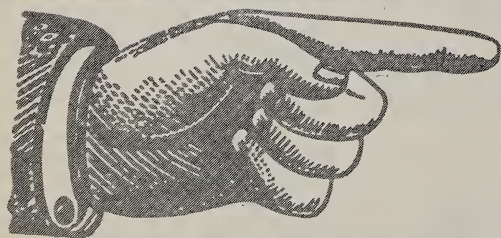
Speaker for the October 18 meeting in the Sheraton Columbus Motor Hotel, Gay and Third Streets, will be Dr. Frank G. Slaughter, physician and novelist of Jacksonville, Florida, whose topic will be "The Physician's Heritage."

November 15 is "Specialty Society Day." See announcement under article on Fall Postgraduate programs in this issue.

*(Continued on Next Page)*



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## LORAIN

Mrs. B. Murray Davidson is the newly appointed executive secretary of the Lorain County Medical Society to succeed Mrs. H. A. Zealley who retired from the post after seven years in the administrative job. Mrs. Davidson has worked in the LCMS office for five years.

## MONTGOMERY

Beginning January 1, 1966, Dr. Charles E. O'Brien will assume the presidency of the Montgomery County Medical Society to succeed Dr. Mason S. Jones. New president-elect for the coming year is Dr. W. J. Lewis, who will be president in 1967.

Other elected officers to assume office on January 1 are Dr. Peter A. Granson, vice-president; Dr. Albert B. Huffer, secretary; Dr. Don E. Sando, treasurer; and Dr. Richard S. Graves, trustee. Dr. William M. Porter was elected delegate, and Dr. John M. Keys, alternate delegate.

Robert F. Freeman is executive secretary of the Society.

## TUSCARAWAS

Members of the Tuscarawas County Medical Society and their wives enjoyed an outing, including a golf tournament, at the Atwood Yacht Club on July 21.

## American College of Surgeons Meets in Atlantic City

Dr. Frank H. Mayfield, Cincinnati neurosurgeon, will be one of the principal speakers when the American College of Surgeons holds its meeting in Atlantic City, October 18-22. It will be the 51st annual Clinical Congress of the organization.

Highlights of the program include 255 research reports, 10 postgraduate courses, 36 panel discussions, 50 film presentations, nine closed-circuit operative color telecasts from the Hospital of the University of Pennsylvania, and 424 scientific and industrial exhibits.

Headquarters hotels will be the Dennis and the Shelburne, with scientific sessions in Convention Hall.

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# Woman's Auxiliary Highlights ...

By MRS. S. L. MELTZER, Portsmouth

Chairman, Publicity Committee

**T**HIS reporter has never before featured a local auxiliary's project in her lead story. But she is so intrigued with Hamilton County's newest extraordinary project, The Apple Tree, that she simply has to give it top billing! Read on, and see if you don't agree that it deserves it . . .

On August 30, The Apple Tree—a day-care center for the children of registered nurses and other key hospital personnel—opened its doors at 220 William Howard Taft Road, within five minutes (more or less literally) driving time of eight hospitals. It is equipped to accommodate 30 children in each of two eight-hour sessions and is open 17 hours a day with a full-time professional staff.

This is Hamilton Auxiliary's "baby," undertaken with the approval of the Council of the Academy of Medicine, designed as a public service to help relieve the hospital nursing shortage. The center is governed by a board of 13 directors, all auxiliary members. Mrs. Richard D. Bryant, a graduate in child care of the University of Cincinnati, is chairman of the board. Incorporated under Ohio law as a non-profit but self-supporting institution, The Apple Tree meets the rigid standards of the City Health Department and the additional requirements for nursery schools approved by the Cincinnati Pre-School Education Council.

To qualify to enroll her children, an applicant must be employed by a hospital as a registered nurse or must be designated by the hospital administrator as key professional personnel. To meet the initial needs of The Apple Tree, capital gifts have been made to date by the Medical Foundation of Cincinnati,

the Schmidlapp Foundation, the Crosley Foundation, the Cincinnati Woman's Club, the Auxiliary of Bethesda Hospital, the Cincinnati Obstetrical and Gynecological Society, the Cincinnati Pediatric Society, the Merrell Chemical Company, Mrs. Gerald H. Castle and the Hamilton Auxiliary. Vice-chairmen of The Apple Tree are Mrs. William H. Lippert in charge of building, and Mrs. Carl F. Schilling in charge of admissions. Mrs. Byron E. Boyer is secretary and Mrs. Calvin E. Warner, treasurer. Other directors include: Mrs. Joseph E. Ghory, Mrs. James A. Wiseman, Mrs. Robert H. Kottee, Mrs. Paul M. Woodward, Mrs. Richard W. Vilter, Mrs. Robert E. Johnstone, Mrs. William P. Ahlering and Mrs. Vinton E. Siler.

Mrs. Bryant, together with Mrs. Schilling, Mrs. Lippert and Mrs. Boyer, served as the "pioneers"—the steering committee who interviewed hospital administrators, consulted public health officials, spoke with specialists in nursing education and obtained financial backing. If ever you doubt the ability of doctors' wives to get important things done, remember The Apple Tree! (Incidentally, where did they come up with that delectable dish of a name? Was "Meet Me Under The Apple Tree" the inspiration?) It is worth noting here too the magnificent newspaper and other coverage given to this new endeavor. All in all, it's quite a project, don't you think?

## Another Day Care Program

Lucas County has something along that line too—the Citizens' Day Care program for School Children staffed by auxiliary members and United Church



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women jointly. Mrs. A. J. Kuehn, a doctor's wife, founded this program in 1952 and is chairman of the board, assisted by such other auxiliary members as Mrs. Spencer Northup, Mrs. R. P. Whitehead, Mrs. Edward Doermann, Mrs. Irvin McConnell; Mrs. Robert Cooke and Mrs. John Hallauer. Purpose of the CDC is supervision of the lunch hour for children of working mothers who would otherwise have no place to go. The youngsters are chosen by the principals of the schools they attend, and include both those whose mothers work and those whose mothers are hospitalized. They are in the 6 to 12 age group, bring their own lunches and then participate in various supervised play and craft activities.

The women volunteers go by the names of "Miss Monday," "Miss Tuesday," etc., (depending on the day of the week they serve) to simplify matters for the children. After all, the little ones would have a job remembering each supervisor's name . . . TLC (tender loving care) for CDC (Citizens' Day Care) is the catch phrase of this outstanding community service in which doctors' wives share the responsibility with the church group women. Come next April 25, the board of directors will entertain with an appreciation luncheon for these volunteers at the Academy of Medicine. This is quite advance notice, to be sure, but already Mrs. Kuehn and her committee have had a brunch get-together at Mrs. Kuehn's home to set up proposed plans for the special program. Good newspaper coverage on all this too!

Mrs. Ward Jenkins is president of the Lucas County group, and Mrs. Richard Schafer, president-elect. A new activity has been scheduled to increase contributions to AMA-ERF — the Bridge-O-Rama organized by Mrs. Paul Geiger. Already two complete teams have been formed, with prospects bright for building up many more in the very near future. Three of the forthcoming monthly auxiliary meetings will have medical themes: safety, international health and medicine in the changing world. Mrs. Daniel Wolff heads the Paramedical Careers Committee which is

busy setting up its work schedule with local schools and area council.

### "Women in Community Service"

They're called the WICS in Cleveland — the organization which has agreed to recruit and screen women in the 16 to 21 age group for the Job Training Program. It has solicited the help and cooperation of the Cuyahoga Auxiliary. The girls are recruited through the schools, social agencies or just by walking into the WICS office. Already the doctors' wives who are registered nurses have given generously of their time in the health screening aspects of the program. Cleveland is one of the cities which has a training center — University House. The girls trained there are from other parts of the country. The point is to take these young women completely away from their present environments, give them a basic education and prepare them with the skills necessary to obtain and hold a decent job.

WICS has no responsibility to University House other than what is specifically asked of it. A recent example: A quick request came into the office for welcoming gifts for new girls who were due to arrive at the Center within two days — 50 of them, no less. Mrs. Joseph Kaplan, liaison for the Cuyahoga Auxiliary, shopped on the run, managed to get the gifts attractively wrapped and delivered them (breathlessly, I would imagine) to the WICS office — in plenty of time!

### From Summit and Scioto Counties

August 11 featured the thirteenth annual Lawn Party and Fall Hat Show of the Summit County group in the garden of Dr. and Mrs. John Dettling. Miss Betty Schlitt of the Wagoner-Marsh Millinery Salon presented the parade of hats. The profits of the day went to the Betty King Dobkin Nurse Scholarship Fund, an auxiliary project which has helped many outstanding student nurses. Mrs. Leonard Phillips was chairman, with Mrs. Charles Reynolds as co-chairman. Others on the committee included: Mrs. George Conger, Mrs. Leon Sacks, Mrs. Robert

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Thompson, Mrs. Douglas Sanders, Mrs. Eugene Feldheimer, Mrs. Joseph Eckert and Mrs. Demetrios Retikas.

Scioto County repeated its mother-teenager get-together recently in the form of a luncheon at Lake Margaret. This unusual kind of meeting with sons and daughters has been made an annual event, to give the doctors' children the "feel" of an auxiliary. The teen-agers got a wisely administered taste of auxiliary activity, followed by a fun program. It all proved once again to be an interesting and successful experiment in public relations with one's own children. Mrs. Alden Oakes is president of the Scioto group, and Mrs. Harlan Williams president-elect.

### Some Important Thoughts

Fall Conference has come and gone. But certainly what was taught there is for all the year. The guideposts as set forth at the State September meeting will remain sturdy and weatherproof and ever helpful. Recall often and thoughtfully what you heard and saw, and be sure to share it all with your membership. Enthusiasm and interest are contagious. If the local officers are enthusiastic and interested, the membership cannot help but catch that enthusiasm and interest. Last year I called Fall Conference a veritable vitamin-packed tonic. Don't you agree that it would be well for every auxiliary member to take a taste?

## Physician Is Honored



*Two outstanding citizens of Apple Creek were honored when the new hall in Apple Creek Community Park was named jointly for them. Standing behind their names are Dr. N. C. Mayer, physician of long standing in the community, and Jefferson Carson, honored by the pharmaceutical profession. Ceremonies were part of the annual Johnny Applesseed homecoming festivals held in the community. Third man in the photograph is Bob Flory, representing contractors for the building.*

Dr. Albert B. Sabin was one of two distinguished service professors of the University of Cincinnati honored recently with special gold medals by the university. The developer of the Sabin oral polio vaccine is now doing research on other viral diseases.

## Poison Information Centers in Ohio

These centers have agreed to cooperate in a program to extend their services to any physician requesting information from them. When a center is called the physician should have four basic facts in mind (1) The full name or brand of the product ingested or inhaled; (2) an accurate estimation of the amount of the particular agent ingested; (3) The time of ingestion; (4) The age and weight of the patient.

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Cleveland	Cleveland Academy of Medicine 10525 Carnegie Ave.	CE 1-4455
Columbus	Children's Hospital 561 S. 17th St.	CL. 8-9783
Dayton	Poison Information Office United States Air Force Hospital Wright-Patterson Air Force Base, Ohio	253-7111 Ext. 78335
Mansfield	Mansfield General Hospital 335 Glessner Ave.	LA 2-3411, Ext. 248
Springfield	City Hospital E. High St. and Burnett Rd.	FA 3-5531, Ext. 226
Toledo	Maumee Valley Hospital 2025 Arlington Ave.	EV 2-3435
Youngstown	Emergency Room Dept. St. Elizabeth Hospital 1044 Belmont Street	RI 6-7231, Ext. 220



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**BUTLER**—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton. 4th Wednesday.

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**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p. m., monthly, Clinton Memorial Hospital.

**HAMILTON**—Robert M. Woolford, President, 47 E. Hollister St., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

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**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, South West St., Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

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1051 Harding Memorial Pky.

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**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.

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Dr. Tilmon H. Smith, New London physician of long standing, is the author of a book, *Home To The Flowers*. Written in the style of an autobiography, the story gives keen insight into the life of a doctor and compares "the good old days" of kitchen table surgery and home deliveries to the practice of today. Still active in hospital staff work in his area, Dr. Smith observed his 82nd birthday in July.


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## Study Seeks Possible Cancer Link From the Use of Pesticides

A study of more than 350,000 cancer deaths in New York State over the past 25 years is being made by the New York State Department of Health in cooperation with the Public Health Service to seek clues as to whether pesticides may have been causative or contributing factors.

The study is the first such large-scale effort to search systematically for changes in cancer rates that might have resulted from the increased use of pesticides during the past 20 years.

The investigation will consist of a survey of records of the New York Cancer Registry dating from 1940 and the statistical plotting of cancer deaths according to types of malignancy, age, sex, occupation and geographic location.

In addition to cancer fatalities, similar analysis also will be made of registry records on 120,000 living persons diagnosed as having cancer during the past five years. Particular attention will be given to cancers of the liver, kidney and brain.

The research work is financed by the pesticides program of the Public Health Service which has greatly expanded its activities to determine adverse effects of pesticides on the health of the general population. New York's State Health Department was chosen for the study because it has the nation's largest and most thoroughly documented cancer registry.

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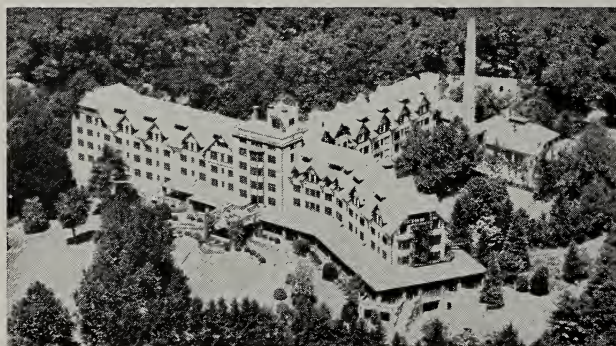
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I certify that the statements made by me above are correct and complete.

Hart F. Page, Managing Editor and Business Manager.

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**Supplied** in bottles of 100 and 1000 tablets.

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sciatica, lumbago; musculoskeletal pain associated with strains and sprains

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# Tomatoes and the Wonderful World Of Ohio — 1835

MYRON T. SEIFERT\*

ONE Hundred and Thirty Years before Governor James Rhodes concocted the idea of making the tomato juice the state-wide beverage, another Ohioan, Dr. J. C. Bennet, was indoctrinating his medical students at Willoughby Medical College, Willoughby, Ohio, with the therapeutic value of this fruit. (Some years later, the Willoughby Medical Department was transferred to Columbus and converted into what became known as the celebrated Starling Medical College.)

Dr. Bennet made a rather exhaustive study of the tomato for that day, when Ohioans took a dim view of the wild fruit. And as he traveled, up and down the "Wonderful World of Ohio" he used every opportunity in his lectures to popularize the "forbidden fruit."

Without benefit of fanfare from the Ohio governor's office, Dr. Bennet succeeded personally in extolling the virtues of the fruit, and his sales pitch to get everyone in Ohio to try the healthful product must have met with some success, judging from the contemporary news accounts of the day. Some scoffed and jeered at the healthful attribute of the fruit, but Dr. Bennet continued his unrelenting efforts.

One of his best commentaries on the fruit, that gained state-wide attention, was reprinted from the *Cleveland Herald* in the September 4, 1835 issue of *The Ohio State Journal and Columbus Gazette*. Here's what the singular document said:

## TOMATO

In a public lecture, introductory to my course on the Principles and Practice of Midwifery, and the Diseases of Women and Children, Hygiene and Acclimatement, in the Medical College of the Willoughby University of Lake Erie, in the fall of 1834, in treating of the Elements of Hygiene, I made the following statement relative to the *Solanum Lycopersicum*, or as it is generally called, Tomato, Love-Apple, Jerusalem-Apple, etc., to-wit:

1st. That it (the Tomato) is one of the most powerful de-obstruents, of the Materia Medica, and that in all those affections of the liver, and other organs, where Calomel is indicated, it is probably the most

effective, and the least harmful remedial agent known to the profession. (It is an invaluable prophylactic, or preventive, against Asiatic or Asphyxiated Cholera.)

2nd. That a chiminal [*sic*] extract will probably soon be obtained from it, which will altogether supersede the use of Calomel in the cure of diseases.

3rd. That I had successfully treated Serous Diarrhoea with this article alone.

4th. That when used as an article of diet, it is almost a sovereign remedy for dyspepsia, or indigestion.

5th. That persons removing from the East or North, to the West or South, should by all means make use of it as an aliment, as it would in that event save them from the danger attendant upon those violent bilious attacks to which almost all un-acclimated persons are liable.

6th. That the citizens in general should make use of it, either raw, cooked, or in form of catchup, with their daily food, as it is one of the most healthy articles of the Materia Alimentaria, etc., etc.

Now, as the above extracts have gone, and are going, the general round of publication, and have had the effect to awaken the public mind to an investigation of the merits of this invaluable, exotic, and as the fruit is now ripe, and fit for use, in every form, it may not be amiss to make a few observations by way of addenda.

1st. In Dunglison's *Elements of Hygiene*, page 300, the learned Author uses the following language:

In Europe, the *Tomato* or Love Apple is chiefly employed as a sauce; but in the United States it is one of the most useful vegetables, although like the Potato, belonging to a family of plants some of which are extremely poisonous. The acid of this vegetable does not agree with every one; (this, however, is not confirmed by experience;) but, on the whole, it may be looked upon as one of the most wholesome and valuable esculents, that belong to the vegetable kingdom.

The same author in his *Medical Dictionary*, page 315, says: "The fruit of this, (*Solanum Lycopersicum*,) called Tomato or Love-Apple, is much eaten in the United States, and with the French, Spanish, Portuguese, etc., forms an esteemed sauce."

2nd. The medicinal qualities of the Tomato, undoubtedly reside in one, or more, peculiar proximate

\*Mr. Seifert, Columbus, is Columbus Public School Historian.  
Submitted July 26, 1965.



principles, which are most likely of an acid nature — perhaps the *Lycopersic Acid* (if such be found to extent,) is the principal.

3rd. As a *medicine*, (until a chiminal [*sic*] extract is obtained,) it should be used raw, or in form of a sauce; as an *aliment*, the same preparations as above stated will be resorted to — the sauce and raw fruit — together with another form — its pickled state; as a *condiment*, the catchup will be made use of.

4th. Mode of preparing the Tomato for the table.

#### 1st. The Raw Tomato

In this state the ripe fruit should be plucked from the vine, and sliced up in vinegar, like cucumbers, with a little pepper and salt; or it may be eaten like other ripe fruit, without seasoning.

#### 2nd. Tomato Sauce

Par-boil the ripe tomatoes until the skin will slip — peel and mash them — and add to every pound of the Tomatoes one ounce of butter, season with pepper and salt, and simmer over a slow fire until perfectly cooked. If however, toast should be added to the sauce, the proportion of butter should be increased.

#### 3rd. Fried Tomatoes

Ripe Tomatoes sliced up, and fried in butter, is, to many, quite delicious.

#### 4th. Tomato Pickles

Pickles are made of the green fruit, by the same process that you would observe in the pickling of cucumbers, or other articles. The ripe fruit may likewise be pickled; and, in fact, it is the preferable article; as it is in that case highly medicinal, and has a much better flavor.

#### 5th. Tomato Catchup (Ketchup)

Take a peck of ripe Tomatoes, (or any other quantity, only observe the proportions,) mash them well together, and simmer over a slow fire until they are dissolved, strain through a fine sieve; after straining, (which requires some pains by mashing and forcing the pulp through the sieve with the hand,) add to this liquid, or pulpy mass, an ounce of cloves, and the same quantity of black pepper grains, one root of garlic, three ounces of horseradish, and a sufficient quantity of salt to make it palatable: boil all these ingredients together over a gradual fire until you reduce the bulk one half; then to each quart add two tablespoonfuls of vinegar. When it is cool, cork it up in bottles and in a little time it

will be fit for use. It should be placed in a cool cellar, and suffered to remain for some time, as it improves by age. The addition of some English walnut liquor to this Catchup, will greatly improve its flavor.

5th. Persons seldom have a relish for the Tomato, *at first*, in any form, but when they *learn to like it*, they generally become extravagantly fond of it in all its preparations. I am satisfied that no person will be without the article, after he becomes acquainted with its virtues, and accustomed to its use.

6th. The able Editor of the *Cincinnati Farmer and Mechanic*, in his paper of July 30, 1834, says —

The Tomato is an annual introduced from South America, and is one of the many horticultural articles for which we are indebted to that country. Its stem, if supported, will rise to the height of six or eight feet, the leaves are pinnated, and have a disagreeable odor when handled. It flowers, when raised in the open air, about the last of May or first of June, producing fruit in July, which continues to ripen until frost. The fruit has an acid flavor, which by use, becomes agreeable to most persons, although not always relished when first tasted. While green it makes a good pickle, when ripe it is put into soups, hashes, and stews; it is also used in confectionaries, and is an ingredient in catsup. In the United States, until within a few years, its use has been principally confined to the southern States, where it has long been a favorite. Of late, however, it has acquired a footing in the east and west, and now appears on our tables in a great variety of forms. In England it is used for soups, and is an ingredient in a distinguished sauce for mutton. In France it is in high estimation, and in Italy scarce a dinner is served, in which it is not in some form a part.

CULTURE. — Seeds that have fallen on the ground in autumn will vegetate in the spring, and the plants thus produced, when they have attained a suitable size, may be set out, at proper distances, in a good wet soil, previously prepared. It will not be safe to rely on this method of obtaining plants. It is better to sow the seeds in seed beds, about the first of April. For early plants, sow in a hotbed, sheltered with glass covers, about the first of March, and when the plants are two inches high, set them out, taking care to keep them covered when the weather is cool, particularly during cold nights. Some few plants might be left in the hotbed, or potted and forced in a green-house. As the Tomato requires free access of air and sun to ripen the fruit, shade should be avoided, and the plants tied up to stakes.

I am induced to make these observations from a firm conviction, founded on long experience and close observation, that many diseases will be cured, and others relieved, in proportion to its more extensive use; and surely as a culinary preparation, it is one of the best of fashionable deserts.

J. C. BENNET, M. D.  
August 21st, 1835

THE OLD AND THE NEW in "The Wonderful World of Ohio" were brought closer together on Governor James A. Rhodes' recent "sell Ohio" caravan. One significant stop was with members of the Ross County Historical Society and others at the Adena State Memorial near Chillicothe. There the group watched the sunrise over Mt. Logan, the vista which inspired the Great Seal of Ohio.

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AND THREATENED  
AND HABITUAL ABORTION**



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of LUTREXIN (Lututrin) on  
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## (reserpine CIBA)

**INDICATIONS:** Mild to moderate hypertension. **CAUTIONS:** Severe mental depression has appeared in a small percentage of patients, primarily in a dosage above 1 mg daily. Usually the patient had a pre-existing, incipient, endogenous depression which was unmasked or accentuated by reserpine. When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required. Daily dosage above 0.25 mg is contraindicated in patients with a history of mental depression or peptic ulcer; use lower doses with caution. Not recommended in aortic insufficiency. Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to reverse hypotension and/or bradycardia. Use cautiously with digitalis, quinidine, or guanethidine. When patients on reserpine receive electroshock therapy, use lower milliamperage and a shorter duration of stimulus initially. Shock therapy within 7 days after giving the drug is hazardous. **SIDE EFFECTS:** Occasional: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation. Rare: anorexia, headache, bizarre dreams, nausea, dizziness. Nasal congestion and increased tracheobronchial secretions may occur in newborn babies of mothers treated with reserpine. **AVERAGE DOSAGE:** *Initial*—Two 0.25-mg tablets p.c. daily. *Maintenance*—Reduce daily dosage to 0.25 mg or less p.c. **SUPPLIED:** Tablets, 0.25 mg (white, scored) and 0.1 mg (white). CIBA Pharmaceutical Company Summit, New Jersey

C I B A

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## Ohio and Neighboring Hospitals On OSU Education Network

The 1965-1966 Ohio Medical Education Network programs began operations in October to 54 subscribing hospitals in Ohio and West Virginia, it was announced by Dr. William G. Pace, director of the Center for Continuing Medical Education at the Ohio State University College of Medicine.

Ohio State Faculty and guest lecturers are included as principals in the program presentations. Speakers and topics for October included the following: Drs. Thomas Shaffer and Robert Murphy, October 18-22, "Contact Sports in School Age Children"; Drs. Phillip Pratt and Robert Atwell, October 25-29, "Chronic Bronchitis and Emphysema."

Coming programs include the following speakers and topics:

Drs. Norman Allen and Martin Sayres, November 1-5, "Macrocephaly in the First Year of Life"; Drs. Harold Roth and William Drucker, both of Western Reserve University, November 15-19, "Gastric Ulcer and Carcinoma";

Drs. Hugo D. Smith and Charles H. Wharton, Children's Hospital, Cincinnati, December 6-10, "Diabetes in Children"; Drs. Bruce D. Graham and Alex Robertson, December 13-17, "Newborn and Their Hospital Problems";

Drs. Norton J. Greenberger and John Jessep, January 17-21, "Jaundice," and Drs. Leon Goldman and Alfred Weiner, both from University of Cincinnati, January 3 - February 4, "Office Dermatology and Skin Cancer."

Also scheduled on OMEN during the year are two diagnosis and treatment conferences, November 8-12 and January 10-14. Two clinical pathological conferences are set for November 29 - December 3 and January 24 - 28.

Fourteen FM radio stations carry the noon-time programs to subscribing hospitals and the general public. They are:

WAKR, Akron; WCWA, Toledo; WERE, Cleveland; WHIO, Dayton; WHIZ, Zanesville; WIMA, Lima; WLEC, Sandusky; WOMP, Bellaire; WOSU, Columbus; WPAY, Portsmouth; WREO, Ashtabula; WSTV, Steubenville; WZIP, Cincinnati, and WTAP, Parkersburg, W. Va.

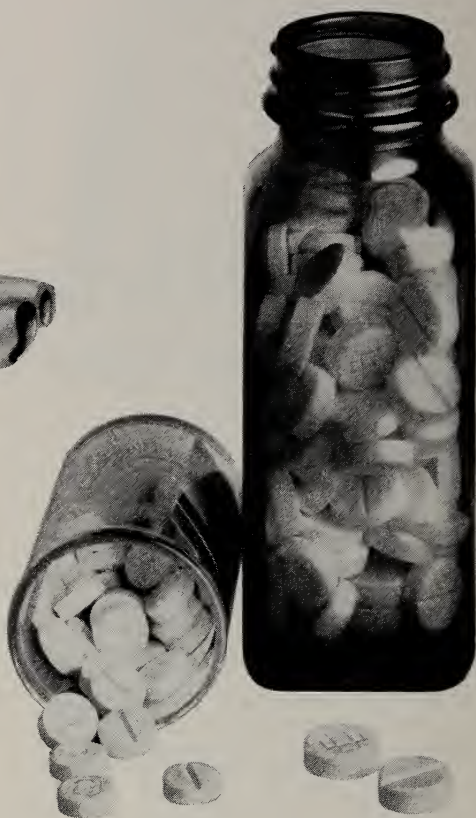
## State Medical Board of Ohio Issues Licenses to 110

The State Medical Board of Ohio recently announced the names of 110 persons who have been issued licenses to practice medicine and surgery in this state, through endorsement of their licenses to practice in states having reciprocity with Ohio, or through certification by the National Board of Medical Examiners.

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**understanding...**



**precedes development**

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

**MERCK SHARP & DOHME** Division of Merck & Co., Inc., West Point, Pa.

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the measure  
of edema...



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**aQUATAG**<sup>®</sup>  
(BENZTHIAZIDE)

NEW FROM TUTAG for fast, emphatic diuretic action with  
a balanced excretion of sodium and chloride and a lower  
potassium loss under normal dosage and diet regimen.

**DIURETIC ACTION:** Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

**DOSAGE:** Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

**PRECAUTIONS AND SIDE EFFECTS:** Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting,

diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

**WARNINGS:** Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

**CONTRAINDICATIONS:** AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

  
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## Physician Named to Newly Created Psychiatric Research Post

Dr. Edward N. Hinko, former Cleveland psychiatrist and recently superintendent of the Ypsilanti State Hospital at Ypsilanti, Michigan, has been named to the newly created position of director of psychiatric research for the Ohio Department of Mental Hygiene and Correction. The appointment was made by Dr. J. Wylie McGough, commissioner of mental hygiene, with the approval of Martin A. Janis, director of the Ohio Department of Mental Hygiene and Correction.

A native of Illinois, Dr. Hinko received his medical degree from Stritch School of Medicine of Loyola University in 1936 and was certified as a diplomate of the American Board of Psychiatry and Neurology in 1947. Before he accepted the Michigan post about two years ago, he was superintendent of the Cleveland Psychiatric Institute. While in Ohio he was a member of the Ohio State Medical Association.

Dr. Hinko's background in psychiatric work included residency training at the Wayne County General Hospital, Eloise, Michigan, and other psychiatric assignments in Michigan and in Indiana as well as service in the Army Medical Corps during World War II.

In announcing the appointment, Dr. McGough said that Dr. Hinko would work closely with Dr. C. Eric Johnston, assistant commissioner of the Division of Mental Hygiene. His assignments will include taking charge of research and training, coordinating all research programs now underway in the department, expanding programs and developing new programs as needs arise. One of his early assignments will be to assist in direction of the psychiatric residency training program at the Cleveland Psychiatric Institute. He will maintain his residence in Cleveland.

## New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Headquarters Office during September. List shows name of physician, county and city in which he is practicing, or temporary addresses for those taking graduate work:

### Cuyahoga

Richard E. Christie, Cleveland  
Donald B. Frankmann, Cleveland  
Daniel D. Hostetler, Jr., Cleveland  
Donald W. Junglas, Cleveland  
Jack E. Penhollow, Cleveland  
Robert H. Schwartz, Cleveland  
Howard S. Sudak, Cleveland  
Thomas M. Tank, Cleveland  
Stanley van den Noort, Cleveland  
William S. Vaun, Cleveland

### Erie

Stannard B. Pfahl, Jr., Huron

### Franklin

John E. Jesseph, Columbus  
Charles V. Mooers, Columbus  
Earl A. Schulte, Worthington

### Fulton

Robert L. Dernlan, Wauseon

### Montgomery

Lenora Gray, Dayton

## Hygroton®

brand of  
chlorthalidone

the longest-acting  
diuretic

**Indications:** Many types of edema involving retention of salt and water.

**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.

**Warning:** With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.

**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

**Average Dosage:** One tablet (100 mg.) daily with breakfast.

**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.

For full details, see the complete prescribing information.

\*Dorhout Mees, E.J., and Geyskes, G.G.: *Acta med.scandinav.* 175:703, 1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.



Geigy Pharmaceuticals  
Division of  
Geigy Chemical Corporation  
Ardsley, New York HY-3992 PC



# Letters To The Editor

## On Safety of Doriden® in Pregnancy

Dear Sir:

This letter is written to correct the erroneous information given by Doctor Robert Kistner's article which appeared in the Scientific Section of *The Ohio State Medical Journal*, December 1964, Vol. 60, No. 12:1125-1129.

Doctor Kistner states in his paper that Doriden is contraindicated in pregnancy because of a chemical similarity to thalidomide which has tragically shown itself to be teratogenic.

There is absolutely no evidence, after eight years of extensive use of Doriden in gravid women that it has any teratogenicity. If there were any suggestion that Doriden were not safe for pregnant female patients, you can be sure that CIBA would not advocate its use. Indeed, you must be aware that under the stringent FDA regulations Doriden would be withdrawn from the market if teratogenicity was a problem or forbidden for use in females with appropriate warnings. Such is not the case.

Although Doriden and thalidomide have a chemical similarity, this does not necessarily imply that they exert the same action or produce similar side reactions. It is general knowledge in biology that minimal changes in the structure of a compound may result in maximal changes in activity. Examples of this type are numerous: androgens, progesterones, and corticosteroids have the same phenanthrene nucleus but the slight chemical changes produce profound alterations of activity. Similarly, other glutarimide compounds with entirely different biologic activities have been marketed.

On the other hand, compounds which are not closely related chemically may possess the same biologic activity; it does not follow that they necessarily have the same side reactions. Many examples of this can be cited: for instance, both reserpine and phenothiazines have tranquilizing properties but their "side reactions" are quite different.

The difference in structure between thalidomide and Doriden are sufficient to postulate that in spite of some similarity of clinical activity, their absorption, metabolism, degradation, and excretion in the body probably are quite different. We know of no metabolic studies with thalidomide, whereas the metabolism of Doriden has been studied extensively and has been reviewed recently in papers by Keberle et al. (Exper. 18:105-152, 1962 and Arch. Internat. Pharmacodyn. 142:117-124, 1963). These investigations show that following its administration, Doriden is rapidly metabolized and excreted, 92-94%, in the form of inactive metabolites conjugated with glucuronic acid and 6-8% as non-conjugated forms. The more rapid rate of elimination of Doriden in comparison with several barbiturates is illustrated in

figure 7 of the 1962 Keberle paper. Thus, characteristic features of Doriden are its complete inactivation with rapid and complete elimination of its metabolites. These metabolic pathways probably do not apply to thalidomide because of the chemical differences.

The extensive world-wide experience with Doriden, which now encompasses more than eight years, strongly indicates that it is not teratogenic. This is in contrast to thalidomide, to which teratogenic reactions were ascribed within a few years after its introduction. No such reports have been received on Doriden. This is supported in part by a report on the use of Doriden during pregnancy by Bennett (Canadian M. J. 80:28, Jan. 1959).

Further, with the knowledge of the thalidomide experience, extensive animal investigations of Doriden have been undertaken. To date, no teratogenic effects have been noted and further studies are in progress.

Without biostatistically valid studies, one can never say absolutely that any drug, substance, or environmental hazard (radiologic, pesticidal, etc.) is not teratogenic; unfortunately, there are no valid baseline statistics available anywhere in this country to permit the required comparisons to be made on a large scale. Any such biostatistical evaluations have been started on a well organized basis only within the past two or three years, and hence can help very little in resolving today's questions as to possible teratogenic influence of drugs and of radiation exposures, to name only two types.

I trust that you will publish this letter in full as soon as possible so that the erroneous impression created by the Kistner paper is corrected.

Sincerely,

CIBA Pharmaceutical Company  
(Signed) ROBERT D. GRAUPNER, M. D.  
September 17, 1965.

\* \* \*

Perry R. Ayres, M. D., Editor  
The Ohio State Medical Journal

Dear Dr. Ayres:

Thank you for your letter of September 24 concerning the letter from Dr. Robert D. Graupner of the CIBA Pharmaceutical Company.

Careful examination of the precise wording of my statement will reveal that I was reporting already published data. My statement reads . . . "it has been suggested that since both glutethamide (Doriden) and demegride have a formula similar to thalidomide, that is, containing a glutarimide ring, that neither of these preparations be given during the first trimester of pregnancy."

I would refer Dr. Graupner to the report of J. A. Black in *Practitioner*, 189:99, 1962, who suggested

that neither of the above compounds should be given during the first 3 months of pregnancy "until more is known of their effects."

It is entirely possible that the 8 year, world-wide experience with Doriden is now adequate to state that it is unquestionably safe during the first trimester of pregnancy. I would be interested to know the exact number of pregnant patients who have taken Doriden during the first trimester of pregnancy and the results pertaining to fetal abnormalities. I agree implicitly with Dr. Graupner in his statement that, "without biostatistically valid studies, one can never say absolutely that any drug, substance, or environmental hazard (radiologic, pesticidal, etc.) is not teratogenic . . ." It would seem reasonable, however, that the physician who administers any drug to a pregnant woman be certain that it is no more dangerous to her or to the fetus than the condition for which the drug is given. Certainly it would be ideal if no medication was necessary during the first trimester of pregnancy. If medication is necessary, it should be selected with caution and it would seem logical that only those agents that have proved to be non-teratogenic over many years of experience be utilized.

Sincerely,

(Signed) ROBERT W. KISTNER, M. D.  
245 Pond Avenue  
Brookline, Massachusetts 02146  
September 29, 1965.

### Drug Information Association Announces Its Objectives

The first annual meeting of the newly organized Drug Information Association was held in Washington, D. C., in October, following the founding meeting in June of this year.

Objectives of the organization have been announced as follows: (1) To have an independent, objective group from the professions; (2) to interchange information about medical communication, methodology, toward saving time, effort and avoiding duplication of effort; (3) to foster collaboration and exchange of information; (4) to teach medical information processing.

Following are the newly elected officers:

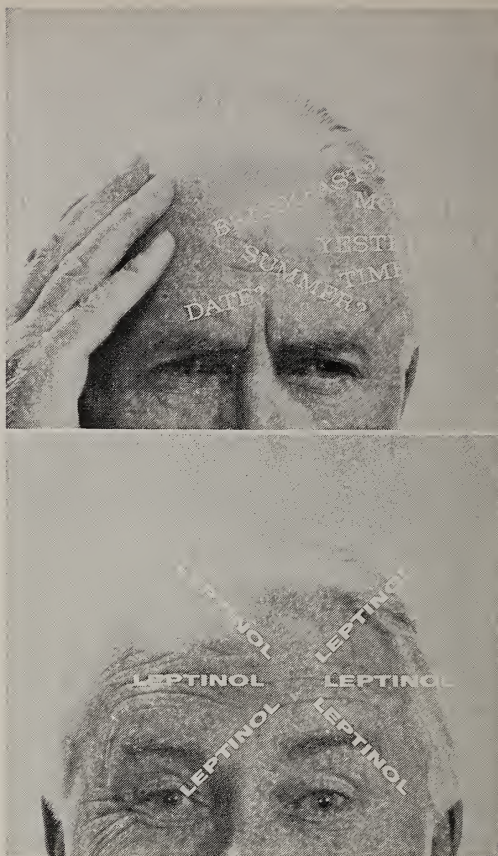
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# Scientific Section

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## Renal Homotransplantation

### A Discussion of Uncertainties

GEORGE DUNEA, M. B., M. R. C. P., M. R. C. P. (Ed.),

and WILLEM J. KOLFF, M. D.

*"One thing is certain and the rest is lies,  
"The rose that once has blown forever dies."*

— Omar Khayyám

ONCE a week a young housewife attends the Outpatient Department of the Cleveland Clinic. She wears a red rose, a hat with feathers, and carries a heavy shopping basket. Sometimes she is accompanied by a struggling boy. She looks no different from the other people in the room and yet her history is very different. Eighteen months ago she was discovered to have bilaterally contracted kidneys. One year ago she was admitted to the hospital in a terminal uremic state. She had hypertension, pericarditis, and heart failure. For six months her life depended on twice weekly treatments with the artificial kidney. Eight months ago she received a renal homotransplant taken from a cadaver. Today her creatinine clearance is 92 ml. per minute and her blood pressure is normal. Her diet is not restricted; she leads a normal life; although she lives on borrowed time, three young children will have spent at least another year with their mother and father.

It is only in the last few years that renal homotransplantation has attained any measure of success.<sup>1-3</sup> The advances in surgical technic, the artificial kidney, and the use of new antibiotics and new immunosuppressive agents<sup>4</sup> have enabled clinicians to achieve

#### The Authors

- Dr. Dunea, Cleveland, former Fellow in the Department of Artificial Organs, The Cleveland Clinic Foundation. Presently at Presbyterian-St. Luke's Hospital, Chicago, Illinois.
- Dr. Kolff, Cleveland, is Head of the Department of Artificial Organs, The Cleveland Clinic Foundation.

some remarkable results. There are about a dozen centers in the world where clinical renal transplantation is being performed and there are more than 40 patients who have lived for longer than one year on borrowed kidneys. At the Cleveland Clinic there are now alive 30 patients who have received renal homotransplants. Four of these patients have now lived for more than 19 months since transplantation. Many other patients have been given several months of useful life and there is little doubt that renal transplantation can be a rewarding procedure. Many aspects of renal transplantation, however, remain poorly understood and our state of knowledge is reminiscent of the times when blood transfusions were performed although there was nothing known of blood groups or subgroups.

#### Ethical Problems

Many of the uncertainties of renal transplantations are moral, social, and ethical.<sup>5,6</sup> They are particu-

From the Department of Artificial Organs, The Cleveland Clinic Foundation, Cleveland, Ohio. Submitted June 29, 1965.

Supported by a grant from The John A. Hartford Foundation, Inc., to The Cleveland Clinic Foundation, for dialysis in the treatment of patients with chronic renal failure, with Dr. W. J. Kolff as principal investigator.

larly acute when living donors are used, but even the use of kidneys from cadavers is not free from criticism. Objections have been raised to the publicity which is inevitably associated with such a program. It is obviously unfair to give hope to many sufferers who cannot be treated at the present time, but neither moral nor financial support for such an undertaking can be expected without publicity. It is often difficult for the physician to know what to tell the prospective recipient. The patient must be given hope and confidence and must not live with the shadow of death hanging over him; yet he must be warned that renal transplantation is no light undertaking and that full cooperation is needed. He already knows one alternative, which is death, since he has practically arisen from it. The other alternative is a somewhat restricted but nevertheless useful life achieved by submitting to twice-weekly dialyses in the hospital or in his own home.

Unfortunately, medicine is inseparable from economics and the question arises as to who should pay for such a program, be it periodic dialysis or transplantation. Should the government or the community be expected to bear the cost or should the patient pay for a treatment that is still experimental, only palliative, and has no guarantee of success? At present only a few patients can be treated and the physician is placed in the unsavory situation of having to decide who will live and who will die. Never before has such a grave decision had to be made, and even leaving this decision to a committee does not lessen the individual's responsibility.

### Clinical Factors

Nowhere are the uncertainties greater than in the technical and clinical field. Many statements that have been made in the past are open to dispute. It has been said that one must be meticulous in the selection of cadaver donors, yet some of the best results have been obtained with kidneys that have recovered from acute tubular necrosis in the donor or where an endarterectomy of the renal artery was needed before transplantation could be performed. Some of the most unpromising recipients have done best and some patients who had everything in their favor worst. The time of ischemia of the cadaveric kidney must be short, yet good function has ensued after periods of anoxia of more than four hours. In some centers, elaborate sterile units have been built to isolate the recipient but the rate of infection is no greater when patients are nursed on the ordinary medical or surgical floors. The handling of cadaveric kidneys before transplantation is of great importance.<sup>7</sup>

Many problems, however, are unanswered. How effective is cardiac massage in preserving the kidney after death of the donor? Would better results be obtained by extracorporeal perfusion?<sup>8</sup> We believe this to be unlikely. Should the cadaveric kidney be perfused or only rinsed out? Is it impossible that some kidneys are damaged by the method of perfu-

**EDITORIAL NOTE:** From time to time in the history of medicine, there have been new developments of such magnitude as to stagger the imagination and credulity of even the most seasoned practitioner. Reaction to them has run the gamut of disbelief, rejection, and suspicion before they were finally accepted. The aura of scientific sophistication that pervades our daily lives in the second half of the twentieth century has modified our reactions somewhat, but developments such as the transplantation of organs from one living being to another still elicit some reaction. This is proper.

The authors of this paper are pioneers in the difficult field of organ transplantation and are to be commended for the great work they are doing. The "uncertainties" they discuss in this paper are not only scientific, which is to be expected, but also moral, ethical, and social. For their sensitivity and concern for these human values, they deserve special commendation. Their discussion of the uncertainties should lead practicing physicians to a sympathetic appraisal of their results.

— P. R. A.

sion? Is the administration of mannitol at the time of transplantation beneficial in preventing acute tubular necrosis? Does it play any part in some of the severe hemorrhages that have been seen after cadaver kidney transplantation? How long should a urethral catheter be left in the bladder after transplantation, if at all?

The diagnosis of anuria in the post-transplantation period remains difficult. Renal scintillograms are of help but even experienced physicians must at times expect to be wrong. The issue as to whether prophylactic antibiotics should be administered routinely after transplantation is still not settled.

### Homograft Rejection

There is little doubt that homograft rejection has been overdiagnosed in the past. Acute renal failure in the immediately postoperative period is often due to poorly understood factors and need not be due to immunologic factors.<sup>9</sup> Cadaver donor kidneys usually go through a two-week period of renal shutdown and if the patient is not maintained by periodic dialyses, he will not survive. Many such failures have in the past been attributed to rejection. Rejection crises in the first few weeks after transplantation should be uncommon when high doses of steroids are used,<sup>10</sup> and one should think twice before making a diagnosis of early rejection. Fever after transplantation is common and often represents a rejection process which has been aborted or modified by the use of high doses of steroids.<sup>10</sup> The diagnosis can be extremely dif-



difficult and even a diagnostic trial with prednisone<sup>11</sup> can be misleading. We have recently seen a patient in whom administration of prednisone suppressed the fever caused by a corticorenal abscess.

While renal transplantation has been made possible by modern immunosuppressive therapy, the role of the individual drugs remains unclear. The value of high doses of steroids in the early days after transplantation is proved by the absence of rejection crisis. The usefulness of azathioprine<sup>4</sup> remains undisputed, but in the past, too high doses have contributed to many fatalities. No one knows what therapy would best prevent late rejection. The assessment of the usefulness of actinomycin C<sup>4</sup> and of local radiation<sup>2</sup> is even more difficult because these measures are usually used in combination with prednisone and azathioprine. The evaluation of splenectomy and thymectomy is difficult because most of the patients die from causes other than rejection. The Denver group has abandoned thymectomy,<sup>1</sup> and at a recent meeting in Washington, most groups felt that splenectomy offered no advantages. An attempt is now being made here to settle this issue by a controlled trial.

The question as to whether bilateral nephrectomy should be performed is even more controversial. It is performed mainly to reduce hypertension<sup>12</sup> and to avoid recurrence of the original disease in the transplanted kidney but it carries a definite morbidity and mortality. While uncontrollable hypertension and obvious abscess formation in the kidneys are indications for nephrectomy, the evidence that removal of the antigenic stimulus will prevent the recurrence of glomerulonephritis, is more tenuous. In several patients, glomerular lesions have developed in the transplanted kidney and the elucidation of the relative importance of rejection, recurrence of glomerulonephritis, and radiation nephritis may need the help of the electron microscope. The problem as to whether active glomerulonephritis should be a contraindication to transplantation, is one that is not settled but which may be of importance in the future.

Contrary to the findings of other groups, we have been unimpressed by the possible importance of multiple blood transfusions in sensitizing the recipient.<sup>3</sup> Some patients have received more than 200 blood transfusions without ill effects on a later transplant. Even less settled is the effect of crossing major blood groups.<sup>2,10,13</sup> No acute rejection has occurred in the six cases where blood groups were crossed.

The mechanism of rejection is still obscure and the role of humoral antibodies unsettled. Morpho-

logically, the emphasis has shifted from the cellular infiltrate to the obliterative vascular changes.<sup>1,14,15</sup> The latter changes may well represent a rejection process, but it must be remembered that both vascular necrosis and obliterative endarteritis are common reactions of blood vessels to a variety of stimuli. Further evaluation is also needed of the frequent finding of tubular atrophy and glomerular lesions in transplanted kidneys.

More remains to be learned, too, about the sudden unexpected changes in tolerance to immunosuppressive drugs, about the odd chemical pneumonias and viral lesions that sometimes follow transplantation,<sup>11</sup> and about the occasional megaloblastic anemias and the rare case of fulminating hepatitis in which the role of azathioprine and the previous blood transfusions is not yet established. These and many others are problems of which one may not even have become aware had renal transplantation remained a laboratory experiment.

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**ATTENTION PROGRAM CHAIRMEN:** We are most anxious to receive for consideration manuscripts, abstracts, or news items based upon lectures, symposia, etc., presented to Ohio physicians or those presented by Ohio physicians to other groups. — THE EDITOR.

# Oral Antidiabetic Therapy

## A Discussion of the Use of Chlorpropamide And Phenformin in Combination

JOSEPH I. GOODMAN, M.D.

IN THE COURSE of treating diabetic patients with oral hypoglycemic drugs the author noted that a combination of chlorpropamide (Diabinese®) and phenformin (DBI®) proved to be more efficacious than either drug alone.<sup>1,2</sup> These observations, noted also by several other observers,<sup>3-6</sup> were sufficiently impressive to warrant more extensive studies along this line. The results of our investigations using various dosage combinations of chlorpropamide and phenformin are presented herein.\*

The patients were carefully selected cases of either primary or secondary drug failures from the author's private practice and the Mt. Sinai Hospital Diabetes Clinic. Most of these patients had been given from one to five different antidiabetic drugs or dosages (on an average) and were, in effect, candidates for transfer to insulin when combination therapy with chlorpropamide and phenformin was instituted. In fact, the stringent criteria of primary or secondary failure poses a difficult test for any different antidiabetic therapy. The series is comprised of 42 patients in whom there were 51 clinical trials of various dosage combinations of chlorpropamide and phenformin. All the patients were maturity-onset diabetics who had taken oral hypoglycemic medication for relatively long periods of time.

### Material and Methods

The patients were seen by the author (personally) at 1 to 4 week intervals throughout the one-year period of the study. The status of a patient's diabetes control is evaluated at each visit by quantitative analysis (for glucose) of the entire 24-hour urine specimen (Somogyi method). Quantitative data make possible more accurate comparisons than can be achieved with random blood sugar determinations or spot checks of urine specimens examined by qualitative tests. Ten grams of glucose excreted in the 24-hour urine is acceptable as the upper limit of satisfactory diabetes regulation in all our diabetic patients.

It should be recognized by physicians that the glucose excretion in most diabetics fluctuates within limits from day to day and from week to week and that these variations are not necessarily abnormal. Also, an adequate period of time must elapse to allow

### The Author

● Dr. Goodman, Cleveland, is Chief of Diabetes Clinic, Mount Sinai Hospital; Assistant Clinical Professor, Western Reserve University School of Medicine.

each antidiabetic drug, or even a larger dosage of the same drug, to exert its maximum effect — several days up to several weeks or, in some cases, even months. Thus, each patient must be observed long enough to ascertain positively that no further diminution in glucose excretion can be expected with the drug being taken and a change of drug is thereby indicated. When another drug, or combination of drugs, effectively lowers the total glucose excretion, a direct comparison of the relative efficacy of the two

TABLE 1-a. Combination Antidiabetic Drug Therapy

Oral Drug	Dose	No. Clinical Trials TOTAL 51	List According to Rank
CHLORPROPAMIDE COMBINATIONS			
Chlorpropamide + Phenformin	500 mg. 75 mg.	1	1
Chlorpropamide + DBI-TD	500 mg. 100 mg.	1	1
Chlorpropamide + Phenformin	500 mg. 50 mg.	37	2
Chlorpropamide + Phenformin	250 mg. 75 mg.	2	3
Chlorpropamide + DBI-TD	500 mg. 50 mg.	1	4
Chlorpropamide + Phenformin	250 mg. 25 mg.	3	4
Chlorpropamide + Phenformin	500 mg. 25 mg.	2	4
Chlorpropamide + Phenformin	250 mg. 50 mg.	3	5
Chlorpropamide + Tolbutamide + Phenformin	250 mg. 0.5 Gm. 50 mg.	1	9

Group average, 2.5

Submitted April 16, 1965.

\*With support of Pfizer Laboratories.



drugs can be made (see Tables 1-a, 1-b, and 2). If, after a sufficient lapse of time, the second preparation fails to maintain the patient's 24-hour glucose excretion below 10 grams, another drug or a larger dose of the same drug is prescribed.

The most effective preparation in any given patient is given a rating of "1" (Tables 1 and 2); the second most effective drug in each patient is ranked 2, etc. Combinations of chlorpropamide and phenformin have been prescribed in cases in which the 24-hour excretion of glucose exceeds 10 grams with one or

TABLE 1-b. Combination Antidiabetic Drug Therapy

Oral Drug	Dose	No. Clinical Trials	Relative Efficacy	List According to Rank
TOTAL 32				
OTHER COMBINATIONS				
Acetohexamide + Phenformin	1.0 Gm. 50 mg.	5	1.0	1
Acetohexamide + DBI-TD	1.0 Gm. 50 mg.	3	1.0	1
Acetohexamide + DBI-TD	0.5 Gm. 50 mg.	2	1.0	1
Tolinase + Phenformin	200 mg. 50 mg.	1	1.0	1
Chlorpropamide + Tolbutamide	250 mg. 1.0 Gm.	2	2.5	6
Tolbutamide + Phenformin	1.0 Gm. 50 mg.	6	3.1	10
Chlorpropamide + Tolbutamide	500 mg. 1.0 Gm.	13	3.2	11
Group average, 7.0				

more antidiabetic drugs used individually, e.g., tolbutamide, 2 Gm., or chlorpropamide, 1 Gm. (primary or secondary failures).

The effectiveness of combinations of chlorpropamide (Diabinese) and phenformin (DBI) in various dosages is the basis for the present study. As stated above, the effect of these combinations in each patient is compared by means of 24-hour glucose excretions examined quantitatively with all the preceding drugs used by that patient (Tables 1 and 2).

Results

There are 51 clinical trials of combinations of chlorpropamide (Diabinese) and phenformin (DBI) in the present study. Inasmuch as different dosages of these drugs were employed in several patients the 51 trials were conducted in 42 patients. In the 42 patients in whom combinations of chlorpropamide and phenformin were prescribed, a grand total of 237 clinical trials of various antidiabetic drugs and combination of drugs had been employed previously, an average of 5.6 preparations per patient. In addition, there were 32 clinical trials using combinations of drugs other than chlorpropamide and phenformin (Table 1-b). The hypoglycemic effects of these

clinical trials were used for comparison and included 153 clinical trials with the various uncombined antidiabetic drugs (Table 2).

The results of the study indicate beyond doubt the superiority of combination antidiabetic drug therapy to any of the drugs individually. In the last columns of Tables 1 and 2, it is apparent that all the dose combinations of chlorpropamide and phenformin are more effective than either drug used alone (Table 2). This superiority of drug combinations prevails when other drugs are used in combination with phenformin (Table 1-b). However, when two sulfonylurea drugs, e.g., tolbutamide and chlorpropamide, are used in combination they are no more effective than either drug used alone.

The combination of chlorpropamide, 500 mg., and phenformin 25 mg. twice daily, was employed most frequently (37 patients) and proved to have a very efficacious antidiabetic effect. In a few patients in whom this combination was less effective than another combination, either increased dosage of either chlorpropamide or phenformin or acetohexamide and phenformin were used. The combination of chlorpropamide with phenformin in other dosages was not employed often enough to be statistically significant. Yet, in the relatively few instances in which they were

TABLE 2. Antidiabetic Therapy. Comparison of Uncombined Drugs and Chlorpropamide-Phenformin Combinations

Drug	Dose	No. Clinical Trials	Rank
TOTAL 153			
Chlorpropamide	250 mg.	7	8
Chlorpropamide	500 mg.	17	6
Chlorpropamide	750 mg.	3	15
Chlorpropamide	1000 mg.	4	9
Group average, 7.8			
Acetohexamide	0.5 Gm.	1	4
Acetohexamide	1.0 Gm.	11	7
Acetohexamide	1.5 Gm.	6	6
Acetohexamide	2.0 Gm.	2	6
Group average, 6.7			
Phenformin	25 mg.	1	9
Phenformin	50 mg.	6	12
Phenformin	75 mg.	1	9
Phenformin	100 mg.	3	13
DBI-TD Capsule	150 mg.	1	4
Group average, 11.1			
Tolbutamide	0.5 Gm.	7	17
Tolbutamide	1.0 Gm.	28	18
Tolbutamide	1.5 Gm.	22	16
Tolbutamide	2.0 Gm.	30	14
Group average, 16.0			
Carbutamide	1.0 mg.	1	19
Metahexamide	150 mg.	1	4
Tolinase	200 mg.	1	9
Group average, 10.0			

prescribed it is apparent (Table 1-a) that they proved quite effective. In fact, the group rating of all the chlorpropamide-phenformin combination, 2.5, shows them to be far superior to the antidiabetic effects of any of the oral drugs used alone (Table 2).

In Table 2 the relative efficiency of each of the antidiabetic drugs is compared with various doses of the drug and with other drugs and combinations in the 42 patients who were given chlorpropamide and phenformin in combination. It is seen that individual drugs are distinctly inferior to combined drug therapy. The chlorpropamide and acetohexamide preparations are obviously more potent than the other drugs.

### Comment

The present study re-enforces the conclusions of others in scattered reports in the literature,<sup>3-6</sup> namely, that combination of existing sulfonylurea antidiabetic drugs with phenformin in various dosages is demonstrably more effective than either drug alone or other known hypoglycemic preparations. The substitution

of chlorpropamide and phenformin in 42 cases of primary and secondary failure shows this particular combination to be particularly efficacious. Acetohexamide and phenformin combinations also proved to be very effective when they were employed in these patients. The superior effect of this combination therapy enables such patients to continue with oral therapy at a time when the institution of insulin is the only other alternative.

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**ORAL HYPOGLYCEMIC COMPOUNDS** (three sulfonylureas, one biguanide) include tolbutamide (Orinase®), which is probably the least potent and most innocuous, has had the most thorough experimental studies, has been used longer than the others, is virtually free of side effects and toxicity, has an impressive safety record, and is widely accepted (due in part to being the first one available). Tolbutamide, in common with the other sulfonylureas and insulin, may stimulate lipogenesis in patients who probably should be treated by dietary means. The others are chlorpropamide (Diabinese®), acetohexamide (Dymelor®), and phenformin (DBI). Selection of patients is probably the most important factor determining the success or failure of oral hypoglycemic therapy. Sulfonylureas are usually indicated in diabetes of less than 10 years' duration with onset after 40 years of age; they may be used with phenformin; they are not to be used in growth-onset diabetes or during surgery, infections, or other stressful periods. Phenformin has generally the same indications as do the sulfonylureas; it may sometimes be used to lower the required dose of insulin; it can be used with sulfonylureas; it has recently been advocated for obese patients; diet is essential. The large initial loading dose of sulfonylureas is no longer used. Use of timed-disintegration capsules of phenformin has minimized side effects. Most secondary failures can be related to poor selection of patient, insufficient dosage, insufficient emphasis on diet, or intervening infection and stresses. The incidence of true secondary failure is probably no higher than 5 or 10 per cent.—**ABSTRACT:** Leo P. Krall, M.D., and Robert F. Bradley, M.D., Boston: *Post-graduate Medicine*, 37:75-81 (January) 1965.



# Intraocular Tumors

## A Discussion of Present-Day Therapy

TORRENCE A. MAKLEY, Jr., M.D.

THE most important intraocular tumors are malignant melanoma and retinoblastoma. These two tumors occur at opposite ends of the life span, retinoblastomas in the very young and melanomas in the older age groups. There are exceptions to every rule however. We recently received in our Ophthalmic Pathology Laboratory an eye from a 52 year old man that proved to contain a retinoblastoma. We have also in our collection a malignant melanoma of the ciliary body from a boy 11 years old.

### Malignant Melanoma

The treatment of choice of an intraocular malignant melanoma has always been enucleation. However, a tumor of the iris can be eradicated by a simple iridectomy if it has not extended into the angle or the ciliary body, if it has not infiltrated the cornea or spread diffusely through the iris stroma, and finally if it does not show evidence of extraocular extension through the anterior emissary channels. It has been pretty well proven that iris melanomas are for the most part of low grade malignancy.<sup>1</sup> Therefore when a lesion of this nature is seen, the patient should be observed. There is time to take photographs and watch for signs of active growth such as the appearance of nutrient vessels, incomplete dilatation, distortion of the pupil, or ectropion uvea. Glaucoma implies that the filtration angle is involved and the lesion is too extensive for local excision. The location of the tumor is important. A peripheral lesion closely approaching the angle area should be excised whereas a similar lesion located near the pupil could be safely followed. The more peripheral tumor should be excised before the angle is involved.

Until recently it was felt that any cutting or manipulation of the ciliary body would result in marked hemorrhage and loss of the eye. A few surgeons, figuring that there was nothing to lose, attacked malignant melanomas involving the ciliary body by a new operation called iridocyclectomy.<sup>2</sup> This has received a lot of attention lately and has salvaged eyes which several years ago would have been enucleated. After a T-shaped scleral incision is made just behind the limbus, the affected iris and

### The Author

● Dr. Makley, Columbus, is a member of the Attending Staffs, University Hospital, and Children's Hospital; Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

ciliary body are removed en bloc. We have had the opportunity to do this operation in only one case, and it was quite successful. There was very little bleeding when the ciliary body was excised.

The treatment of choroidal melanomas is enucleation. The tragedy of having a malignant melanoma in an only eye has spurred some to look for other means of treating these lesions. Attempts have been made to destroy these tumors by surface diathermy. The technical difficulties are formidable and the procedure has not been used extensively in the United States. There is one report in the German literature of 20 patients being treated in this way with no deaths from proved metastasis over a 20 year period.<sup>3</sup> We have recently treated a melanoma with diathermy, and the tumor is certainly becoming necrotic but follow-up has been only six months.

### Light Coagulation

In recent years we have had the light coagulator and the laser at our disposal for treatment of various eye disorders. The light coagulator invented by Meyer-Schwickerath has proved itself useful over and over in the treatment of retinal detachments. Meyer-Schwickerath has used the light coagulator to treat intraocular melanomas. He is very positive that he has destroyed 24 tumors in this way. Of course, the tumors have to be accessible and not too large. He does not advocate treating tumors which are elevated more than 6 diopters, or tumors which extend into the ciliary body. This form of treatment is contraindicated, too, if there is an accompanying serous retinal detachment.<sup>4</sup>

Our experience in treating melanomas with the light coagulator has been very discouraging. The first step in using the light coagulator is to surround the entire tumor with light burns placed in normal choroid and retina. The aim is to close choroidal

From the Department of Ophthalmology, Ohio State University, Columbus, Ohio 43210. Submitted February 25, 1965.

blood vessels. The entire tumor mass is then coagulated using the normal intensity of coagulation for one to one and a half seconds. The blanching of the treated tissue makes it impossible to coagulate the tumor further. During the next few weeks the white surface of the coagulated area assumes a dirty gray appearance, and at this stage a second light coagulation is carried out. Coagulation may be repeated an indefinite number of times depending on the thickness and size of the tumor mass until one feels it is destroyed. Using the high intensities of the light coagulator, you can hear an audible pop when the light beam hits the tumor and frequently there is liberation of bubbles of steam. Of the four eyes we have treated two were subsequently removed because we did not feel the tumor was completely destroyed. The remaining two patients refused enucleation even though we strongly advised it. One man is still living and well three years after treatment and the second man is living and well 30 months after treatment.

Westervelt, Brandon, and Zeeman raised a question, "Does enucleation of an eye with malignant melanoma prolong life in the elderly?" In their experience little is gained as far as longevity is concerned in patients over 60 years of age.<sup>5</sup> The tumor is undoubtedly less malignant in older people. This makes evaluation of therapy difficult in the patients whose eyes we did not remove.

The big variable in checking the efficacy of the light coagulator in treating malignant melanomas is the lack of a histological diagnosis in a so-called cure. Are these lesions nevi or melanomas of a very low grade malignancy? Certainly the eyes we enucleated showed very little effect of the coagulator on the tumor itself. The retina and retinal pigment epithelium and only a few surface layers of the tumor were destroyed (Fig. 1).

#### Irradiation

The doses of irradiation which the eye can tolerate are thought by most to be useless in treating malignant melanoma. Stallard, however, reports destroying

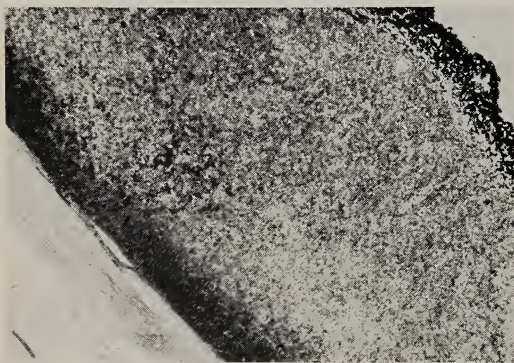


FIG. 1. Malignant melanoma treated with light coagulation. Only the very superficial layers have been affected by the treatment. X 40

malignant melanomas by application of a radioactive source over the sclera precisely over the base of the tumor. This is effective if the neoplasm is 8 mm. or less in diameter and has not broken through Bruch's membrane. He uses one application of radioactive cobalt 60 which delivers 40,000 r at the base and 14,000 r at the summit.<sup>6</sup>

One must keep in mind that not every black lesion in the fundus is a malignant melanoma. A choroidal hemorrhage (Fig. 2), a choroidal detach-

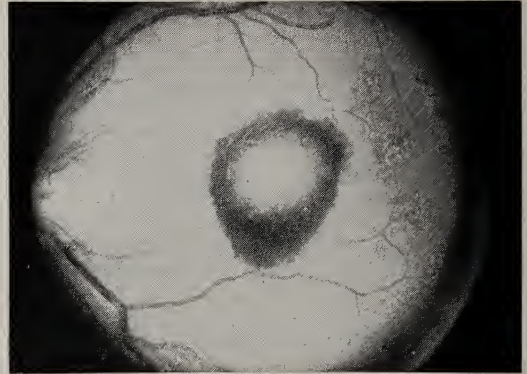


FIG. 2. A localized hemorrhage in the macula simulating a malignant melanoma.

ment, a melanocytoma of the optic nerve head, and disciform degeneration of the macula are all benign and should be considered in the differential diagnosis. Reese has emphasized the importance of examining carefully the other eye.<sup>7</sup> Frequently pathologic change is found which is of great importance in arriving at the correct diagnosis. Most agree that an emergency enucleation is not indicated the first time one sees a pigmented lesion. Observation for a month or six weeks may be indicated, especially if there is any doubt.

#### Retinoblastoma

The treatment of retinoblastoma is a different problem from that of intraocular malignant melanoma. Here, there is a sense of urgency. This tumor occurs in the very young, arises from highly undifferentiated cells of the developing embryonic retina, and is very malignant. There is no sex or race predilection. If the tumor is present in one eye only, immediate enucleation is indicated. It is very important that a long portion of optic nerve be obtained in an effort to place the operative section beyond any extension of the tumor in the nerve. This is best done by passing a heavy silk traction suture through the insertion stumps of the internal and external rectus muscles so as to engage some of the adjacent sclera.<sup>7</sup> Put the optic nerve on tension by pulling outward on the traction sutures and cut the optic nerve by passing the scissors along the nasal wall of the orbit. A nerve stump of less than 5 mm. is inadequate. According to Reese, if the nerve is free of tumor,



these children have better than a 75 per cent chance of surviving.<sup>7</sup>

Unilateral retinoblastoma is almost always far advanced when first noticed. But what about the occasional small tumor that is discovered early? Should this eye be enucleated or treated by more conservative means? The location of the tumor is important. Certainly early enucleation should be done if the tumor is sitting adjacent to the optic nerve. If elsewhere the tumor may be irradiated or radon seeds could be implanted on the sclera overlying the tumor. Diathermy has been used but most effective of all is the use of the light coagulator to destroy single tumors. This has the disadvantage of not treating the entire retina. We know that retinoblastomas frequently arise from multiple sites in the retina.

### Combined Intracranial and Orbital Operation

Several years ago a number of articles appeared advocating a combined intracranial and orbital operation for retinoblastoma.<sup>8</sup> First the intracranial portion of the nerve between the chiasm and the optic foramen was removed, and, 12 to 13 days later, the enucleation was performed. There are several reasons why this is no longer done. It formerly was felt that the tumor extended along the nerve to invade the brain and that this was the way most patients died. Now it is known that retinoblastoma usually does not extend much beyond 10 mm. of the optic nerve, that is, to the site where the central retinal vessels enter the nerve. Here the tumor gains access to the arachnoid sheath and spreads very rapidly. If the tumor is beyond the cut section of the optic nerve, you can almost be sure it is far beyond where you could get at it surgically. An analysis of 17 autopsies found that death was caused more often by blood-borne distant metastases than by extension into the cranial cavity.<sup>9</sup> Finally, the delay in enucleation is certainly contraindicated.

### Bilateral Tumor

If retinoblastoma is bilateral, it is usually much farther advanced in one eye. This eye is removed and the second eye can be treated by other means if the lesion is not too large. Certainly, if the tumor is large in the second eye and there is no hope of saving any vision, it should be enucleated too. Until recent years treatment of the second eye consisted of radiation alone with dosage levels so high that a large percentage of eyes were eventually lost. Reese, in his first book on tumors, recommended 5,000 to 8,000 r times two. This book was published in 1951. In 1953, the prognosis both for life and for saving the second eye was vastly improved by the combined treatment with chemotherapy and x-ray. With x-ray alone, using 5,000 to 7,000 r times two, Reese was able to save only 36 per cent of his patients with useful vision. With triethylenemelamine and 3,250 r, they now claim 70 per cent cures with some useful vision, 20 per cent living but blind, and only 10 per cent deaths. Blodi reported that, prior to com-

bined therapy, 9 of 11 bilateral cases ended up blind; whereas, with chemotherapy and x-ray, only 3 of 13 patients lost both eyes.<sup>10</sup> Most feel that adding chemotherapy to the regimen makes it possible to cut the dose of x-ray to the point where the normal structures of the eye can tolerate the radiation.

### Chemotherapy

The chemotherapeutic agents used in treating retinoblastoma have been varied. In 1952, Cooper used nitrogen mustard with radiation successfully. In 1953, Reese chose triethylenemelamine (TEM), a close relative of nitrogen mustard, because it could be given orally, intravenously, or intramuscularly. With oral TEM and x-ray given to a series of 20 patients, he was able to save 70 per cent with useful vision. With intramuscular TEM, he was able to save 89 per cent of 19 patients. In the very desperate cases where the tumor fills much of the eye or where there is seeding into the vitreous, he gives the TEM intra-arterially at the beginning of x-ray treatment and at the end of x-ray treatment. He reports 40 per cent cures in these cases in a series of 54 patients. The dosage he uses is .08 mg/Kg. of body weight both intramuscularly and intra-arterially.

The toxic effects of platelet and white cell depression are also indicators of the efficacy of treatment. The hemogram in these children has to be watched very carefully, and it is well to keep the depression of the white cells to around 3,000 and the platelets to 100,000. No therapeutic results can be expected from the TEM unless hematologic depression occurs. At Ohio State University we use Cytosan<sup>®</sup> because it is considered safer, less toxic, and easier to administer than TEM. It can be administered intramuscularly or orally, and the dose varies a little depending upon the hematologic response. If the bone marrow is depressed too much, there is rapid recovery when the drug is stopped. Thio-Tepa<sup>®</sup> is another alkylating agent, which is effective.

### Light Coagulation

If the retinoblastoma is not too large and it is accessible, light coagulation is very effective. The tumor itself is white and most of the light will be reflected so not enough heat is generated to destroy tumor cells. However, if one seals off the tumor from its blood supply by destroying normal surrounding retina, gradual necrosis will take place. We have treated three cases with the light coagulator alone. There were two recurrences. In one case the recurrence was treated successfully. In the other the eye was lost even after x-ray was given as a last resort. In five others the light coagulator has been used in conjunction with chemotherapy and radiation.

The drawback of all purely local forms of therapy, i.e., light coagulation, radon seeds, and diathermy, is that you are not treating the retina as a whole. Because of the multicentric origin of retinoblastomas, it is not unusual for a new tumor mass to pop up

elsewhere after the first mass seen has been destroyed. We consider light coagulation an adjuvant which can be used in conjunction with x-ray or chemotherapy for the eradication of small recurrences or new tumors as they arise. Reese feels that tumors larger than 8 disc diameters should not be treated with the light coagulator. Diathermy has been tried by a number of people but its value is extremely limited. It has the same drawback as the photocoagulator plus the fact that the perforation may be a factor in spreading the tumor.

### Residual Tumor

If tumor remains in the portion of the optic nerve left in the orbit or if sections of the eye show tumor leaving the eye by way of the emissaria, then Reese believes radiation of the orbit with 4,500 r over a four week period should be started at once.<sup>7</sup>

### Recurrent Tumor in the Orbit

Reese recommends exenteration of the orbit, radiation, and intracarotid TEM for recurrent disease in the orbit.<sup>7</sup> Of 32 cases he has had, only three are alive. This seems to indicate that in the vast majority of these poor children the tumor has spread to distant parts at the time one sees the orbital recurrence. One wonders if the family and child should be subjected to the trauma of exenteration if death is inevitable anyway.

Figure 3 is a picture of a 4 year old boy who had the left eye removed because of a retinoblastoma. He did well for nine months when it was noted that the prosthesis kept coming out. The reason was quite obvious on examination, as the orbit was filled with recurrent tumor. After considerable deliberation on the relative merits of exenteration, radiation, and chemotherapy, we decided to irradiate the lesion as the only form of therapy. The tumor melted away and the socket seemed clinically free of tumor. The child lived comfortably for six more months, when he died of metastases. An autopsy was not done so it cannot be proved that the orbit was free of tumor but there was no sign of recurrence clinically. We feel just as much was accomplished for this patient by



FIG. 3. The upper photograph shows recurrence of retinoblastoma in the left orbit. In the lower picture the socket appeared clinically free of tumor two months after x-ray therapy. (3000 r using cobalt 60 machine)

conservative therapy as by the more radical exenteration.

### Summary

Treatment of the two most common intraocular tumors is considered. Intraocular malignant melanoma is frequently difficult to diagnose. Because the tumor is not rapidly growing, time for consideration and consultation is in order. Retinoblastoma is very malignant and there is an urgency to make the right diagnosis and carry out treatment.

Light coagulation, diathermy, chemotherapy, high voltage x-ray, and newer surgical approaches are discussed and evaluated.

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**H**YPERPARATHYROIDISM AND CANCER.—A case is reported in which hypercalcemia was accidentally discovered during hospital admission for unrelated reasons. The patient was found later to have anaplastic carcinoma of the cervix uteri. It was at first difficult to decide whether her hypercalcemia was due to the carcinoma or to primary hyperparathyroidism. The hypercalcemia was unaltered by radium therapy to the cervix and later by our standard cortisone test. Furthermore, she had minimal subperiosteal phalangeal erosions and a slight rise in plasma alkaline phosphatase level. A diagnosis of primary hyperparathyroidism was therefore made. A parathyroid tumor was then found and removed.—C. E. Dent, M. D., M. R. S., and L. C. A. Watson, M. B., M. R. A. C. P., London: *British Medical Journal*, 2:218-221, July 25, 1964.



# Mastoiditis and Chronic Otitis Media

## A Discussion of Current Concepts of Surgical Management

MICHAEL M. PAPARELLA, M.D.

ACUTE or chronic mastoiditis with otitis media was a dreadful disease to have in the days before the discovery of antibiotics. Not infrequently, it resulted in serious secondary complications. The use of antibiotics in the management of infection in the middle ear and mastoid has reduced the incidence of complications. For example, whereas a simple mastoidectomy was a common treatment for acute mastoiditis in former days, it is now seldom indicated. The patient is now seen earlier with acute otitis media, and antibiotic treatment, with myringotomy when indicated, obviates to a large extent the development of mastoiditis and the necessity for further treatment to the mastoid.

On the other hand, many problems of chronic suppurative otitis media and chronic mastoiditis are still prevalent. This can partially be explained on the basis of development of resistant strains of organisms and other predisposing factors leading to the development of granulation tissue and cholesteatoma in the middle ear and mastoid. Such factors as faulty development of the middle ear and mastoid and childhood illness which may affect the middle ear (adenoiditis, serous otitis media, sinusitis and other upper respiratory infections, mechanical trauma to the ear drum or middle ear, and certain systemic illnesses) may contribute to a lowering of resistance of mucosal lining in the middle ear and mastoid and to eustachian tubal dysfunction which progresses to a state of chronic otitis media and chronic mastoiditis.

The role of cholesteatoma in this condition is an important one. Cholesteatoma is a baglike cystic structure lined by keratinizing squamous epithelium containing debris with deposition of cholesterol. It is usually found in the "attic" of the middle ear but may exist in other parts of the middle ear and mastoid as well. As infection continues the cholesteatoma grows by expansion, producing changes of osteitis in adjacent bone. It usually destroys part or all of the ossicles thereby causing conductive deafness. This tumor-like tissue can erode bone covering the inner ear, the facial nerve, and adjacent areas of the brain thereby causing complications which we still see too frequently today.

### *The Author*

● Dr. Paparella, Columbus, Assistant Professor, is Director of Otolological Research Laboratory, Department of Otolaryngology, The Ohio State University College of Medicine.

The classical operation that has been used for this disease is the radical mastoidectomy procedure. This includes the eradication of all the diseased mastoid and the removal of ossicles in the middle ear. This well proven procedure has been useful in transferring a dangerously draining mastoid infection into a safe dry ear. However it usually results in a 40 or 50 decibel hearing loss if the patient has normal inner ear function. In addition certain patients will require periodic visits for cleansing of their mastoid cavities for the rest of their lives.

During the past 13 years, the development of microsurgical techniques for the ear has been made possible with the introduction and use of the binocular operating microscope. This is a direct result of the contributions of two noted German otologists (Wullstein and Zoellner), who introduced the concepts of tympanoplasty, an operation employing microsurgical plastic techniques to reconstruct damaged ear drums and ossicles, when possible, in order to improve hearing. They formulated a classification of tympanoplasty based on the extent to which useful ossicles remained after infection, which largely determines the chances for a return of hearing and to what degree. For example, if all of the ossicles are destroyed there is less chance for a good hearing result than if all three ossicles (malleus, incus, and stapes) are intact and normal. In the latter instance a type I tympanoplasty is performed, which then necessitates only a grafting of the ear drum, and a return to normal hearing can be expected providing the inner ear functions normally.

The availability of microscopic surgical techniques not only provides for a better opportunity for hearing restoration in patients with ear infection but also allows for a more meticulous removal of infected tissues. The primary aim in treating otitis media and mastoiditis is still to eradicate the disease. Although

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everything possible is done to achieve a hearing result, this is of secondary consideration.

The following techniques have been useful in managing the patient with extensive mastoid and middle ear infection. The chief contributors have been Rambo, Guilford and Schuknecht. The procedure combines three basic component parts, which are done at one operation: (1) The exenteration of all available air cells in the mastoid to insure removal of mastoid disease; (2) The obliteration of the mastoid cavity utilizing a postauricular muscle pedicle which helps eliminate the mastoid cavity problem and produces a canal of near normal size; (3) Utilization of tympanoplasty techniques in the middle ear to remove infection and to reconstruct the sound-conducting mechanism.

### Technique of Complete Mastoidectomy, Obliteration, and Tympanoplasty

An incision is made in the postauricular sulcus to allow maximum exposure to the mastoid and middle ear (Fig. 1).

A muscle pedicle is dissected and is hinged inferiorly (Fig. 2). This contains part of the temporalis muscle, the sternocleidomastoid muscle, and adjacent subcutaneous tissues. An adequate exposure to the

mastoid results, and the pedicle will be used at the termination of the procedure to obliterate the mastoid bowl.

The mastoid is totally exenterated and widely saucerized as in the classical radical mastoidectomy technique, and the tip of the mastoid is removed (Fig. 3).

Diseased tissue is removed from the middle ear (cholesteatoma, granulation tissue, etc.) using fine instruments (Fig. 4). The dotted line which is seen on the facial ridge (under which the facial nerve

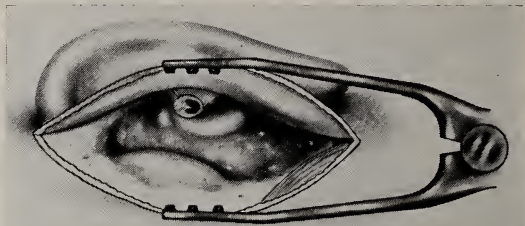


FIG. 3. The exenteration of the mastoid air cell system (mastoidectomy).



FIG. 4. The facial ridge is lowered and the dotted line indicates bone which is removed to uncover the hidden "caves" (facial recess and sinus tympani).

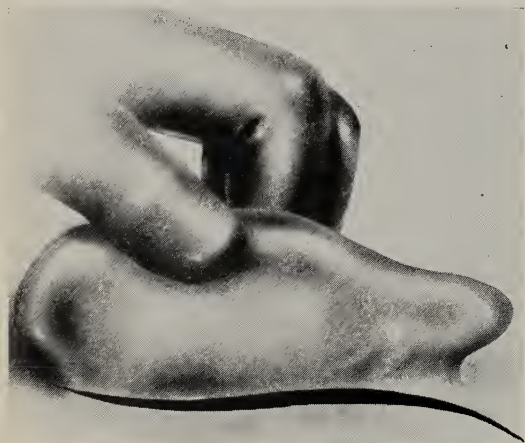


FIG. 1. The postauricular incision.

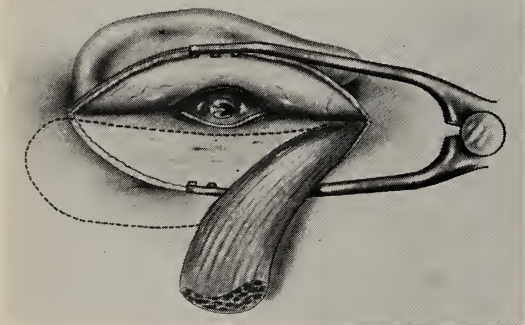


FIG. 2. The development of a muscle pedicle hinged inferiorly.

is located) indicates bone to be removed in order to expose both the oval and round window areas. In addition this provides exposure to certain hidden areas in the bony ridge (facial recess and sinus tympani) which allows for a more complete removal of disease and for a better recipient site for the graft to be placed subsequently.

For purposes of clarity, in this drawing, the ossicular chain and middle ear are shown to be normal and intact. In ears with chronic mastoiditis and otitis media, however, this is seldom the case. The dotted line over the middle ear (Fig. 4) indicates the



location of a typical kidney-shaped perforation of the ear drum which is occasionally seen in such patients although a defect in the upper part of the drum (pars flaccida) is much more common. In such patients, usually a type III tympanoplasty (the entire stapes remains) or a type IV tympanoplasty (only the base of the stapes remains) is necessary.

After the middle ear is cleared of infection, the stapes and oval window area are "prepared" by removing mucosal epithelium thereby allowing the graft to "stick" in this area (Fig. 5). Sound waves will then transmit directly to the stapes. In these cases, usually the lining of the middle ear is badly

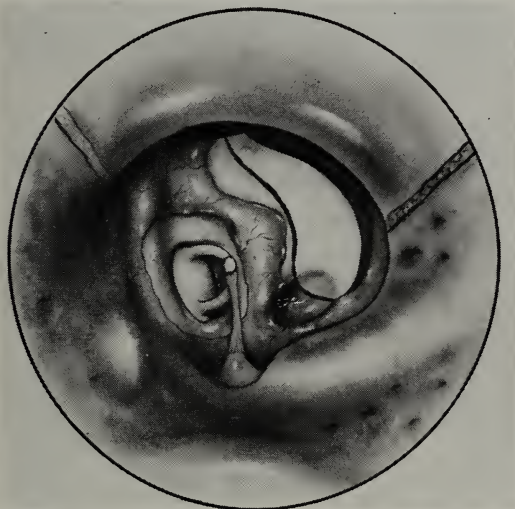


FIG. 5. The stapes area is "prepared" for the graft and a crescent of silastic connects the round window area to the eustachian tube.

diseased and must be removed. Since it is important to protect the sound pressure differential which must occur at the round window, it is important to provide a "scaffold" which will prevent the graft from adhering to the area of the round window thereby providing a communication channel for air from the eustachian tube to the round window. In addition, this scaffold allows for the regeneration of normal middle ear mucosa. This effect is provided by inserting a small slip of silastic sheeting (Siliconized Rubber—Dow Corning Chemical Company) into the hypotympanum connecting the eustachian tube to the round window (Fig. 5).

A skin graft cut at a thickness of 13/1000 of an inch from the medial surface of the arm is removed with a DaSilva dermatone. This is then shaped to size so that it will cover the middle ear with its anterior edge reflecting up the anterior canal wall and on to the facial ridge posteriorly. The graft comes in contact with the head of the stapes thereby "tenting" the stapes in a type III procedure. In a type IV procedure it is quite important to indent the graft into the oval window niche against the

base or foot plate of the stapes. The muscle pedicle is then placed over this and the ear is packed utilizing strips of surgical rayon followed by cotton soaked in Cortisporin®. The drawing (Fig. 6) shows the graft in position tenting the stapes, the muscle

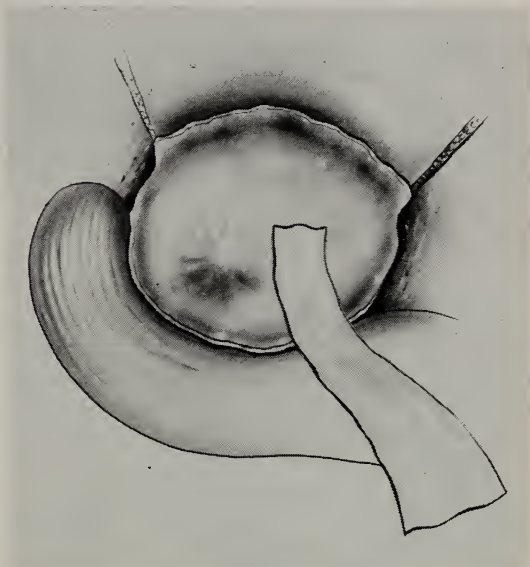


FIG. 6. The skin graft and fibromuscular pedicle are positioned and the packing procedure has begun. Note the "tenting" of the stapes.

pedicle is diagrammatically seen to fill the mastoid bowl below, and the first strip of surgical rayon has been placed over the graft and muscle pedicle to begin the packing procedure.

Occasionally the ossicular chain will be intact in which case attempts are made to preserve this structure. Depending on the location of infected tissue in the middle ear, adequate exposure can sometimes be obtained by removing the incus and by then repositioning it after diseased tissue has been removed. The incus is placed in its usual position and is supported by Gelfoam®.

In certain cases, the middle ear will be filled with diseased tissue and yet the ossicular chain is intact. In such instances we have found it useful to remove the incus, malleus, anterior drum remnant, and anterior canal skin flap in continuity as one unit. This is accomplished first by the wide removal of bone around the incus and malleus (atticoantrotomy). The ligamentous attachments to the incus and malleus are then severed. Technically the most difficult and important step is cutting the tensor tympani tendon. This is best accomplished by passing a small right angled knife between the long process of the incus and the malleus staying close to the under surface of the neck of the malleus so as not to damage the facial nerve which lies immediately beneath.

It is necessary to have ear drum remaining anterior

to the handle of the malleus to provide a recipient site and support for the skin graft to be placed subsequently. The anterior drum remnant and annulus are then denuded by removing the outer layer of epithelium.

The incudostapedial joint is disarticulated with a knife. The structures to be removed are now free from all middle ear attachments. A horizontal incision is made at the top of the bony portion of the anterior auditory canal. This anterior canal skin flap is then elevated carefully and dissected downward being careful to elevate beneath the anterior fibrous an-

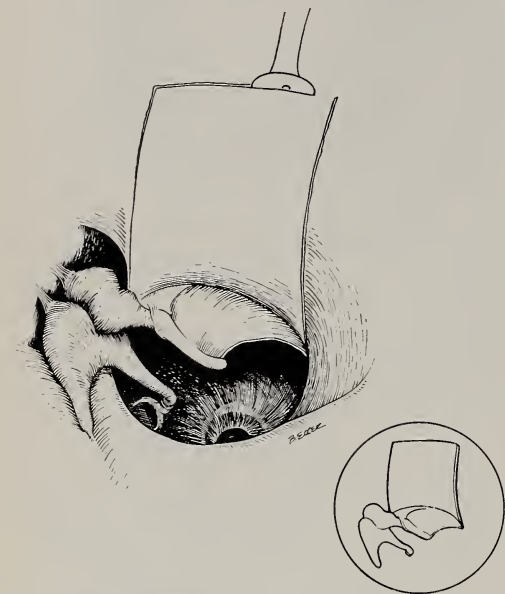


FIG. 7. When disease is extensive in the middle ear but the ossicular chain is intact, this ossicle preservation technique can be used for wide exposure. The insert shows the removed "unit" consisting of incus, malleus, drum and anterior canal skin.

nulus (Fig. 7) and the "unit" is removed and placed in Ringer's Solution.

After the graft has been carefully packed into position, the postauricular wound is sutured and a small rubber drain is inserted (Fig. 8).



FIG. 8. The wound is closed and drained.

### Discussion and Conclusions

The exact type of tympanoplasty procedure which is used should be modified after the extent and location of pathology found at time of surgery. For this reason it is not always possible to determine exactly what techniques might be necessary except at time of surgery.

In chronic suppurative mastoiditis and otitis media usually a type IV or a type III tympanoplasty will be indicated. Using microsurgical techniques to treat this condition will provide for the conversion of a wet draining ear into a dry one in virtually every instance.

In addition, the adaptation of microsurgical techniques to restore middle ear function will in many instances provide an improvement of hearing to a serviceable level. This of course is particularly important in patients having bilateral ear infection. The achievement of a good hearing result will depend to a large extent on the availability of adequate mucosal lining in the middle ear space and on the patient's eustachian tubal function.

**STUDY OF HODGKIN'S DISEASE AND LYMPHOSARCOMA.**—The cooperation of physicians is requested in a study of Hodgkin's disease and lymphosarcoma being conducted by the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Particularly desired are patients who have had no previous treatment or minimal prior treatment. All clinical stages of biopsy-proven disease are acceptable. The major purpose of the study is to determine the curative potential of intensive radiotherapy in localized cases and to evaluate combination chemotherapy and X-irradiation in patients with generalized involvement.

Physicians interested in having their patients considered for the study may phone or write to: Paul P. Carbone, M.D., The Clinical Center, National Institutes of Health, Building 10—Room 12N-228, Bethesda, Maryland 20014; Telephone: 656-4000, Ext. 64251 (Area code 301).—ANNOUNCEMENT, Clinical Center, NIH, June 1965.



# Heterotopic Pregnancy

## Report of a Case Complicated by Polyhydramnios and Partial Small Bowel Obstruction

DELBERT D. BLICKENSTAFF, M.D., and DARYL M. PARKER, M.D.

**H**ETEROTOPIC (combined intrauterine and extrauterine) pregnancy is a rare occurrence, there being about 480 cases reported. In a thorough review of the literature, Vasica and Grable<sup>5</sup> state that the possible outcome for the abdominal pregnancy, aside from viability, is maceration, abscess formation, mummification, and lithopedion formation. In the present case, there was maceration and abscess formation in the abdominal pregnancy, causing partial small bowel obstruction, and polyhydramnios in the uterine pregnancy.

### Case Report

The patient was a 39 year old white woman, who had three normal pregnancies and one complete spontaneous abortion. She was examined first on March 3, 1964 and was found to have a 14 week pregnancy. The uterine fundus reached 15 cm. above the pubic bone. During the next few weeks, she was examined three times because of spotting, rapidly increasing uterine size, and pain in the abdomen and back. On April 3, 1964 she was hospitalized.

Physical examination showed the uterine fundus to reach the level of the costal cartilages. The fetal parts could not be palpated, and the fetal heart sounds could not be heard. Because of the polyhydramnios a serious fetal abnormality was suspected. Therefore, a transvaginal therapeutic abortion was performed, with removal of 3,200 mls. of amniotic fluid, placenta, and fetal parts. No specific fetal abnormality was recognized.

Postoperatively the patient developed paralytic ileus, which was treated with nasogastric suction for two days. Although bowel sounds returned and the patient began eating, the bowel remained moderately distended with gas. Except for back pain, however, her general condition seemed to improve and on the eleventh postoperative day she was sent home.

One week later, the patient was readmitted to the hospital because of increased abdominal distention and pain in the abdomen and back. She began vomiting, and a diagnosis of partial small bowel obstruction was made. On the following day, the abdomen was explored. A necrotic fetus was found in the area of the cecum, and a partially liquified placenta was found along the left colon with adherent small bowel. The necrotic abdominal pregnancy was evacuated, and the abdomen was drained. The patient made an uneventful recovery.

### Discussion

According to Gelb,<sup>1</sup> the incidence of heterotopic pregnancy is about one in 30,000 pregnancies. Horner<sup>3</sup> described a case of combined pregnancy, which was followed by small bowel obstruction due to adhesions developing after resection of the tubal pregnancy.

### The Authors

- Dr. Blickenstaff, Versailles, is a member of the Staff, Wayne Hospital, Greenville, Ohio.
- Dr. Parker, New Madison, is a member of the Attending Surgical Staff, Wayne Hospital, Greenville, Ohio.

In none of the cases reviewed was polyhydramnios mentioned as a complication. In regard to treatment, Vasica and Grable<sup>5</sup> state that "If heterotopic pregnancy is diagnosed in the early months of gestation, the possibility of massive intra-abdominal hemorrhage is too great a hazard to permit the condition to continue." Hreshchyshyn, Bogen, and Loughran,<sup>4</sup> after analyzing 101 cases of abdominal pregnancy, advocate early intervention with removal of the placenta. George and Daub<sup>2</sup> reported a case where the abdominal pregnancy was removed early and the uterine pregnancy was allowed to survive to term. In most cases, where both intrauterine and extrauterine pregnancies survived, the diagnosis was not made until late in the pregnancy.

### Summary

A case history is presented in which a 39 year old white woman was found to have a combined pregnancy complicated by partial small bowel obstruction and polyhydramnios. The diagnosis was not made until laparotomy was performed in order to relieve the bowel obstruction. The management of combined pregnancy is discussed.

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From Wayne Hospital, Greenville, Ohio. Submitted April 10, 1965.

# The Danger of Ruptured Spleen In Infectious Mononucleosis

A. A. YURKO, JR., M.D., F. G. WINEGARNER, M.D., and D. L. KINSEY, M.D.

**R**UPTURE of the spleen is a rare but recognized catastrophe associated with infectious mononucleosis. This abdominal crisis has been reported to follow minor trauma,<sup>1</sup> physical examination,<sup>1,2</sup> and may even occur spontaneously.<sup>1</sup> In the highly organized college community, physicians responsible for student care should be cognizant of this association. An illustrative case is presented.

## Case Report

This 22 year old college student presented at our Emergency Room with the following history. At 8:00 A.M. he was involved in a minor skirmish. He received what he described as insignificant and poorly localized blows to the abdomen. He proceeded to attend his scheduled lecture that morning. His initial symptoms occurred in the classroom and were described as a "dizzy feeling." He was then reported to have fainted. He was seen at the Student Health Division where the physical examination was inconclusive. Because of their concern, however, he was transported to our Emergency Clinic.

He was found to be alert and cooperative with normal vital signs; however, the assumption of the upright position caused the previously mentioned "dizzy feeling." He complained of abdominal discomfort. He had no shoulder pain.

A small abrasion was found over the left costal margin. The abdomen was generally tender but mostly so in the right upper quadrant. There was marked guarding and rebound tenderness referred to the right upper quadrant.

The initial white blood cell count was 12,400 with a normal differential except that a few atypical lymphocytes were found. The hemoglobin, hematocrit and serum amylase were normal.

A history of infectious mononucleosis was obtained. This diagnosis had recently been confirmed by an elevated heterophile agglutination. His blood pressure which had previously been normal fell to near shock levels but responded to whole blood transfusion. He was taken directly to the operating suite. A ruptured spleen was removed. His postoperative course was uneventful.

## Discussion

This case represents a typical splenic rupture following minor trauma in a patient with infectious mononucleosis. It is well documented that splenomegaly is associated with infectious mononucleosis. This enlarged friable spleen is especially susceptible to trauma.

Patients in the college age group who complain of abdominal pain following insignificant abdominal trauma should have the benefit of medical attention. If the physical findings suggest an acute abdomen, infectious mononucleosis with associated splenic rupture should be suspected.

The campus Health Service should be acutely

From the Department of Surgery, The Ohio State University Hospitals, Columbus, Ohio. Submitted March 30, 1965.

## The Authors

- Dr. Yurko, Columbus, is Senior Resident, Department of Surgery, The Ohio State University Hospitals.
- Dr. Winegarner, Columbus, is Senior Resident, Department of Surgery, The Ohio State University Hospitals.
- Dr. Kinsey, Columbus, is Assistant Professor, The Ohio State University College of Medicine.

aware of this impending catastrophe in any patient with infectious mononucleosis. These patients, therefore, should be carefully instructed to limit their activities and to seek medical evaluation of any abdominal pain. A waiting period of four weeks has been suggested before the resumption of normal activities.

## Summary

From a review of the literature<sup>4-8</sup> and the preceding case report, it is concluded that: (1) Minor abdominal trauma in patients with infectious mononucleosis may cause splenic rupture. (2) Having established a diagnosis of infectious mononucleosis, it is the physician's responsibility to instruct the patient to limit his physical activities for a period of four weeks. (3) Patients with the symptoms of infectious mononucleosis and abdominal pain require careful medical evaluation. (4) The fact that infectious mononucleosis is so prevalent in a college community and that splenic rupture is the leading cause of death in patients with infectious mononucleosis, demands that we view this so-called benign disease with more respect.

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# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

COLIN R. MACPHERSON, M. D., *President*

## PRESENTATION OF CASE

IN THE four months before death this white man, aged 75 years, had three admissions to Ohio State University Hospital. Ten years earlier the patient had a right lower lobectomy for a "spot in his lungs." The patient had smoked two to three packs of cigarettes per day for the past 35 years. At the time of bilateral hernia repair, 18 months prior to admission, enlarged glands were found. X-ray therapy was given at that time. The first admission was for evaluation of a sore lump on his lower back that had been present for two months and was not responding to treatment.

Positive physical findings were confined to the skin. On his back was a large necrotic area at the level of L5. He also had small nodules over the anterior chest and lower abdomen. There was a circumscribed reddened nodular plaque over the sternum. Laboratory studies on this admission were within normal limits. A skin biopsy from his back was diagnosed as "Mycosis fungoides." The plaque on his chest was diagnosed by biopsy as basal cell carcinoma. He received antibiotic therapy, and 12 x-ray treatments were given to his back.

The second admission was two months later. Many new spots had developed on his chest and back; they were described as firm, red, slightly tender nodules located intradermally. The ulcerated area on his back was healing. He also had a 2 by 3 cm. non-tender right inguinal node. Biopsy of this node was performed. He received chemotherapy (Velban®) with some regression of the skin nodules.

The final admission one month later was because of inability to stand. For 10 days he had noted a burning sensation over the soles of both feet, made worse by walking, and progressive weakness of his legs, particularly of the left. On the morning of admission he was unable to stand or to move his legs because of extreme weakness. He also complained of a numb feeling that started in his hip and progressed down the leg.

On physical examination the nodular lesions remained as before, scattered over both the anterior

## Presented by

- Robert L. Wall, M.D., Columbus, and
  - Colin R. Macpherson, M.D., Columbus;
- Edited by Dr. Macpherson.

and posterior aspects of the trunk. The patient had decreased sensation in both lower extremities with absent vibratory sense. Other modalities of sensation were intact. The deep tendon reflexes were 1 plus and equal bilaterally on both upper and lower extremities. He had no pathologic reflexes or clonus.

Laboratory studies on this admission revealed a hemoglobin of 13.4 Gm. and normal white and differential blood counts. The urine was normal. The blood urea nitrogen was 25 mg. per 100 ml. The total protein and the serum electrolytes were normal. An electromyogram showed evidence of diffuse lower motor neuron disease. An x-ray of the chest revealed some emphysema. Portions of the sixth and seventh ribs were missing, probably due to the old surgical procedure on the right side. X-rays of the lumbar spine were normal.

## Hospital Course

The patient's hospital course was marked by progressive weakness. He was started on vitamins B<sub>6</sub> and B<sub>12</sub> because of the possibility of toxic neuritis. His mental status deteriorated, and he had several markedly elevated blood pressure readings. On lumbar puncture a yellow fluid was obtained which contained 2000 mg. of protein per 100 ml.; cell count could not be done because of technical difficulties. A tap of the cisterna magna was then done. The opening pressure was 170 mm. of water, and the fluid again was yellow. The protein was 700 mg. with a strongly positive Pandy reaction; there were 250 red cells and 23 white cells (95 per cent polymorphonuclear leukocytes, 5 per cent lymphocytes). The patient tolerated these procedures well.

The following day he developed incontinence, was catheterized, and a residual urine of 600 cc.

Submitted August 25, 1965.

was found. He developed ptosis of his left eye with dilated pupil on that side, but both pupils reacted to light and accommodation. He also developed left sixth nerve paresis. The patient continued on a steady course until about five days later (16th hospital day), when he suddenly developed hypotension with rapid, thready pulse, cyanosis, and a temperature of 102°F., and soon died.

#### CLINICAL DISCUSSION

DR. CARR: I hope this doesn't disqualify me as moderator of this session, but I took care of this patient. The last chapter of his life completely baffled several excellent clinicians. I would like to add that this man had poikiloderma. These x-ray-like changes on his skin did not result from x-ray therapy in this case.

DR. WALL: I also saw this patient. He was an elderly man and he was quite loquacious. It was rather difficult, however, to get a very fine, detailed history. About 10 years before his death, or when he was 65, he had a spot in his lung and was taken to a tuberculosis hospital, where he had a lobectomy, apparently for diagnosis, and was told that it was not tuberculosis. He had not too much trouble for nearly 10 years. He then had bilateral hernia repair and apparently at that time was found to have some lymph nodes in the area. Whether any of these were biopsied or not we do not know. He seemed to doubt that any were. This is not really unusual, unfortunately. His doctor told him that he could have had Hodgkin's disease, but nothing more definite. He apparently did receive some x-ray treatment. Whether he had any skin lesions at that time we are not sure. At the time he presented here he had a large necrotic area over the sacral area and some very peculiar skin lesions, and it is unfortunate that we don't have photographs of his gross appearance.

DR. MACPHERSON: All I can show you is what the skin looked like at the time of autopsy, but I think it is probably fairly representative although the ulceration had by this time healed. You will notice that he had multiple bluish nodules. He also had quite a bit of thickening and erythema of the back.

DR. WALL: I think also it is fair to say that this was a big, raging, open, necrotic, oozing sore earlier.

DR. MACPHERSON: You can see the scar just above the sacral region.

DR. WALL: He had been a heavy smoker of two to three packs of cigarettes a day, which makes us wonder about his original solitary nodule, but there were no sequelae for 10 years.

At this time he had been treated with some anti-biotic therapy and had also received 12 x-ray treatments to his back. A skin biopsy was taken at this time. The plaque on his chest was diagnosed as basal cell carcinoma, and this was different from the other

biopsy of the skin. Dr. Macpherson, will you show the biopsy slides?

DR. MACPHERSON: These are the deeper layers of the skin. It is quite edematous and is infiltrated by cells. This infiltration is very bizarre. The cells are very large; they are quite variable in appearance although they are probably all of the same cell-type. These are giant cells, mitoses, and the diagnosis on this section, which is quite representative, was mycosis fungoides.

#### Mycosis Fungoides

DR. WALL: What really is mycosis fungoides? Fortunately, we don't see it too much; it is a horrible disease. Actually, in the broadest terms, we think of it as a lymphoma of the skin, and at the time that you see it, even in its disseminated form, it may well still be confined to the skin. Yet on biopsy it looks like a lymphoma, many times like a proliferative atypical Hodgkin's lesion, many times as an atypical reticulum-cell sarcoma-like lesion, with many necrotic areas, a great deal of secondary infection, and is rather unresponsive to conventional treatment. It also occurs in a localized form and can respond to local x-ray therapy, sometimes to excision followed by x-ray therapy. Other isolated areas can then be treated with x-ray therapy intensively with good responses. Only very late does mycosis fungoides become a systemic disease in most people.

One of the horrors of it is that these people can be covered with lymphoma that you see externally and they may smell so bad that they are socially totally unacceptable. Yet these people may feel pretty good except for their external condition. As the disease progresses they may become terribly introverted and consider suicide. Part of the tragedy is that you may not improve this picture. He did receive 12 x-ray treatments; the exact dose is not stated and we don't know how much it was.

He then was admitted only a couple months later with recurrent ulcerated areas. His back had healed considerably from the x-ray therapy, but he had now developed dissemination — spots, plaques, infiltrative lesions — over a wider area. At this time it was suggested that because of the dissemination it might well be a case for chemotherapy. He was given intravenous Velban®, 10 mg. on two occasions. This is a fairly good-sized dose. His response was one of considerable improvement in his skin lesions. This is a very temporary form of treatment, unfortunately. Velban, intravenously, is sort of a hit-and-run drug; it has a transient effect on many lymphomas, quite dramatic sometimes, but the effect is quite evanescent in most patients.

He was admitted the third time, and this was a real problem. His skin lesions had improved somewhat, but he had a totally new set of problems at this time, with inability to stand. This occurred about 10 days prior to his admission or about two



weeks after he received Velban therapy. He had a burning sensation in the soles of his feet, weakness of the legs, and this continued to progress. It was a little more on the left than on the right; he couldn't stand, he couldn't move his legs because of extreme weakness. He complained of a numb feeling from his hips down. The nerve conduction time was inhibited.

His laboratory findings were not too helpful. His chest x-ray showed no changes, and no bony changes were seen in the spine. Lymphoma in bone can form a number of different lesions. In Hodgkin's it can form a characteristic sclerotic lesion that looks practically like marble. Osteolytic lesions are relatively uncommon. Many people have Hodgkin's involvement of bone proven at autopsy or biopsy, yet the painful bone may have shown nothing radiologically that was consistent with Hodgkin's disease or other lymphoma.

The patient got worse. He was given vitamins. The reason for giving vitamin B<sub>6</sub> and B<sub>12</sub> was the possibility that it could be a peripheral neuropathy produced by Velban therapy, which is a common side effect. However, this has been reversible in every patient we have seen; it is usually transient and doesn't last more than a week or two in most people. It is quite severe. Some have developed a significant ileus with considerable abdominal distention that is quite frightening and probably of neurologic origin from Velban. Lumbar puncture showed the striking finding of 2 Gm. per cent of protein, which is quite tremendous. They weren't really satisfied, so they did a cisternal puncture and here they found a lot of protein too, a positive Pandy reaction, some red cells and white cells, none of the white cells being of diagnostic significance except that there was a predominance of polys. They were not abnormal cells in any way. He developed incontinence and had a neurologically involved bladder. He developed some ptosis of his left eye and progression including a peripheral sixth nerve unilaterally, and he succumbed.

I think there are two major questions. First, what was his primary disease? I think anyone that has seen mycosis fungoides would probably agree that that is what this was — both by biopsy and by general appearance of the lesions themselves. Did he have antecedent Hodgkin's disease lesions of the lymph nodes at the time of his herniorrhaphy? We don't know. This would be a little bit unusual development of the disease because it most frequently occurs primarily in the skin and only disseminates late. Could these be regional lymph nodes, possibly related to mycosis fungoides lesions of his skin? This is possible.

So if he has mycosis fungoides then the second question is: What is the terminal neurologic picture? I don't think this is easy to understand. Was this an actual involvement with his primary disease? Has it actually gone through into his cord from the

ulcerated lesion in his spine and disseminated upwards? I have never heard of this happening in mycosis fungoides. Most lymphomas, Hodgkin's for example, will cut off the blood supply sometimes as they go through from the retroperitoneal position into the extradural space and cause cord compression. To actually get inside the cord is a very late involvement. It can cause compression of the cord and present an emergency picture that needs to be cared for promptly.

Actual central nervous system involvement of the brain with Hodgkin's is very rare. But this might not be a classical mycosis fungoides. There are certain people with lymphoma that develop very peculiar peripheral neuropathies that are not understood but are not related to therapy. Everyone sees these, nobody understands them. I have never heard of one progressively ascending like this and with the spinal fluid changes that he has. It usually is ill-defined, usually extremity peripheral neuropathy and not particularly modified, or brought on, or aggravated by therapy. Could he have a mycotic infection of his meninges? cryptococcosis, aspergillosis, or histoplasmosis? There is no evidence to suggest that this is true from examination of the spinal fluid.

I think the last thing we would have to consider regarding this neuropathy is whether it is conceivably related to the x-ray therapy he received over his lower cord, over the necrotic area. I would really doubt this. As you know, central nervous system tissue is pretty tolerant to doses of x-ray that we would give for a lymphoma-like lesion. Is Velban incriminated here because of this terminal progressive neurologic picture? We have not seen it, but we haven't used Velban that long. It is a relatively new chemotherapeutic agent. Now with the oral form of Velban I have not seen any neuropathies. So this could possibly be a Velban reaction. The temporal relationship of a week or two subsequent to intravenous therapy is usual, though some people will get their toxicity manifestations in only a few days.

MEDICAL STUDENT: What are the spinal fluid findings in neuropathy due to Velban or to the lymphomas?

DR. WALL: We haven't done many spinal taps in Velban neuropathy, we have had no reason to. They seem to get over it rather rapidly. In the couple that we have done there haven't been any dramatic changes at all.

DR. BEMAN: What did the bone marrow show?

DR. WALL: He had two bone marrow examinations, which were normal.

DR. SASLAW: Was there sugar in the spinal fluid?

DR. RUPPERT: We had a lot of trouble with this spinal fluid because it had so much protein in it that it just jelled in the tube. Cultures for fungi were

all negative. The blood sugar was 93 and the lumbar fluid sugar 15 mg.; the cisternal sugar was 63 mg.

DR. WALL: What do you think about post-radiation radiculopathy, Dr. Harris?

DR. HARRIS: I think it would be unlikely from what is described here. The radiation given usually for mycosis fungoides is a soft radiation, just to reach beneath the skin, and he had only 12 treatments.

#### CLINICAL DIAGNOSIS

1. Mycosis fungoides.
2. Toxic neuropathy.

#### PATHOLOGIC DIAGNOSIS

1. Mycosis fungoides with polymorphic systemic lesions.
2. Infiltration of spinal cord roots.
3. Probable toxic neuropathy.
4. Bronchopneumonia.

#### DISCUSSION OF PATHOLOGY

DR. MACPHERSON: When this man came to autopsy he had skin lesions which we agree were mycosis fungoides. The surprising development was a very marked swelling of the right testicle. It was about three times the size of the left. There was remarkably little, apart from that. He didn't show the usual signs of lymphoma, and about the only lesions that we were able to see grossly were bronchopneumonia with one old granuloma but no evidence of carcinoma. In addition he had inflammation of the bladder which we assumed was due to catheterization. When the spinal cord was examined closely he had nothing except one little plaque in the meninges at about the level of T10. Other than that the gross appearance of the cord and of the brain was quite normal. Histologically, however, we came across some rather interesting patterns.

Skin taken at autopsy shows a relatively uniform cell-type here, more so than we saw in the antemortem skin biopsy. The diagnosis here would be reticulum-cell sarcoma. Here we have the picture of the lymph node biopsy and this is quite different from the other pictures. There are a lot of eosinophils, there is fibrosis, and also a degree of pleomorphism and some Reed-Sternberg giant cells — in other words, typical Hodgkin's disease. The testis shows complete disappearance of normal architecture and the cell-type is quite uniform, resembling reticulum-cell sarcoma again. There is also lymphomatous infiltration of the pancreas, spleen, adrenals and kidneys, but the degree of pleomorphism seen in these organs resembles what was seen in the first skin biopsy. The bone marrow and liver were free of infiltration. The bronchopneumonia is of acute bacterial type. I shall ask Dr. Liss to report on the changes in the central nervous system.

DR. LISS: First of all, two negative findings must be reported: There was no mechanical block

in the spinal canal to account for the markedly elevated spinal fluid protein, and second, there was no tumor infiltration of the meninges as is sometimes seen, with thickening and opacification of the meninges. The small nodule described at the level T10 was not lymphoma but just a small fibrous lesion of uncertain etiology — certainly not recent. Histologically, the remarkable finding is the presence of diffuse infiltration of the anterior and posterior spinal roots by lymphoma. It is not distorting the normal architecture nor causing enlargement of the peripheral nerves, but in high magnification one can see that there is a patchy arteritis with foci of fibrinoid necrosis in small vessels which are surrounded by tumor cells. These cells are very pleomorphic and resemble the original skin biopsy rather than any of the other patterns seen.

These changes are confined to the peripheral nerves in the thoracic and lumbar areas of the cord, extending only just up into the cervical region. In the brain itself we see very little — some patchy demyelination, some proliferation of astrocytes and oligodendrocytes, but of minor degree. Vascular lesions are not seen in this area.

How can we explain the clinical picture? In the case of the more distal peripheral nerve lesions there can be no question that the infiltration is responsible for symptoms, possibly mediated through, or exacerbated by, the vascular lesion. In the brain, however, it is not so simple, and here we must postulate either a toxic effect from the Velban, of unusual type, or else a "toxic" effect of the lymphoma itself, which would be even more unusual in a way. I think we cannot offer any single lesion, but must explain what happened as a combination of direct lymphomatous infiltration and toxic effect of the chemotherapy. The vascular lesion may be the result of either or both but is probably responsible in part for the symptoms.

DR. MACPHERSON: Thank you, Dr. Liss. It remains only to add that this patient's disease was unusual in other respects as well. In mycosis fungoides the lymphomatous process usually turns out to be a reticulum-cell sarcoma, less commonly a Hodgkin's, but here we had not only classical areas of both these processes, but other areas where the degree of pleomorphism and lack of differentiation were in striking contrast to the picture seen in the testis, for example. The immediate cause of death was probably the neurological involvement together with the bronchopneumonia.

DR. WALL: Although we have never seen another case with the same strange complications that this man had, he illustrates the fact that when one sees one of these unfortunate patients with mycosis fungoides, no matter what is tried, one had better not expect anything very dramatic in the way of a response. When they get to the stage of dissemination there is not much that one can offer.



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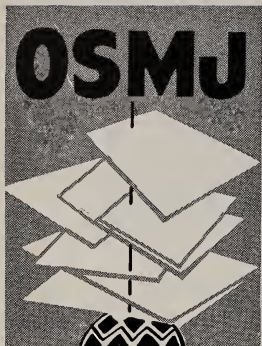
Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

**SEARLE**

*Research in the Service of Medicine*



# NEWS AND *Organization Section*

## Proceedings of The Council . . .

Minutes of the Regular Fall Meeting Held in Columbus,  
September 17-19; Matters Considered and Actions Taken

A REGULAR meeting of The Council of the Ohio State Medical Association was held on September 17, 18, 19, 1965, at Stouffer's University Inn, Columbus. All members of The Council were present. Others attending were Drs. Edwin H. Artman, Chillicothe; John H. Budd, Cleveland; Richard L. Meiling, Columbus; Charles A. Sebastian, Cincinnati; George W. Petznick, Cleveland; Carl A. Lincke, Carrollton; Edmond K. Yantes, Wilmington, AMA delegates; Drs. Frederick P. Osgood, Toledo; J. Robert Hudson, Cincinnati; Robert S. Martin, Zanesville; Harry K. Hines, Cincinnati, AMA alternate delegates; Mr. Wayne E. Stichter, Toledo, legal counsel; and Messrs. Page, Edgar, Gillen, Traphagan and Moore, members of the OSMA staff.

The following invited guests also attended the meeting: Dr. Emmett W. Arnold, Columbus, Ohio Director of Health; Dr. Anthony Ruppertsberg, Columbus, chairman, OSMA Committee on Maternal Health; Dr. William R. Graham, Wakeman; Dr. David A. Chambers, Cleveland, chairman, OSMA Committee on Insurance; Mr. David B. Weihaupt, Chicago, AMA Field Representative; Mr. Charles H. Coghlan, Columbus, Executive Vice-President, Ohio Medical Indemnity, Inc.; Mr. Spencer W. Cunningham, Vice-President, Mr. Lloyd Scott, Account Executive, Daniels-Head and Associates, Portsmouth; Mr. Dale Harrison, Mr. Lowell Jackson, Mr. F. W. Stevenson, representing the Insurance Company of North America.

### Minutes Approved

By official action the minutes of the meeting of The Council held on July 24-25, 1965, were approved.

### Reports by Councilors

The Councilors reported on activities in their respective districts.

### Membership Statistics

Membership statistics were presented by the Executive Secretary as follows: OSMA membership as of September 15, 1965, 9,912, compared to a total membership of 9,805 on September 15, 1964, and 9,933 on December 31, 1964. He reported that of the 9,912 OSMA members, 8,924 were affiliated with the AMA.

### Policy on Waiver of Dues for 1966

By official action The Council adopted the following policy with respect to waiver of annual dues for the calendar year 1966:

(A) That dues for new members in practice, affiliating with the OSMA during the last six months of the calendar year 1966, namely, July 1 to December 31, inclusive, shall be \$25.00, one-half of the regular per capita dues of \$50.00. The pro-rating of dues shall not apply to former members reaffiliating.

(B) That the following procedures shall apply during 1966 with regard to OSMA annual dues of members on extended active duty in the military service or in the United States Public Health Service:

1. State Association dues for 1966 shall be waived for members on extended active duty in the military service or U. S. Public Health Service.



2. State Association dues for 1966 shall be waived for physicians who were members of the Association in 1965 and who enter such services during the calendar year 1966 before the payment of 1966 dues.

3. A refund of membership dues will not be made if a member enters such services in 1966 after his 1966 dues are received at the Columbus office of the Association.

4. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

(C) Annual Ohio State Medical Association dues for 1966 for a physician serving in an internship or residency program approved by the AMA Council on Medical Education who meets the membership eligibility requirements of the OSMA and who is accepted into membership by a component medical society shall be \$7.50. Such intern or resident shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges.

#### Reissuance of Charter to Lorain County

The Council authorized the issuance of a duplicate copy of the charter of the Lorain County Medical Society.

#### Report of Ohio Director of Health

Dr. Emmett W. Arnold, Ohio Director of Health, addressed The Council concerning present and future activities of the department. He announced that 93 hospitals are sending phenylketonuria tests to the State Laboratory under the present voluntary testing program. Ninety-nine hospitals are conducting tests according to Dr. Arnold. The Ohio Public Health Council will be developing regulations for the mandatory PKU testing program which will become effective July 1, 1966.

He said that no applications have been processed for sewage treatment facilities nor for hospitals under the Federal Economic Opportunity Act. Federal matching funds on an 80-20 basis amount to \$4,104,000 in the hospital category.

Dr. Arnold also discussed the new law relating to Hill-Burton hospital facilities.

#### 1966 Annual Meeting

Mr. Traphagan reported on meetings of the Committee on Scientific Work held on August 28 and 29, 1965. By official action The Council approved the report as presented.

#### New Section Secretary Appointed

Dr. Sidney Kay, Cincinnati, was appointed secretary of the Section on Obstetrics and Gynecology for

1965-1966, which position was left vacant when the elected secretary was unable to serve.

#### Survey at 1966 Annual Meeting

A request from a survey organization for permission to apply for Annual Meeting booth space was approved, subject to staff investigation.

#### Dr. Platter To Be Honored

The Council decided to honor Herbert Morris Platter, M.D., Columbus, for his long years of service to the medical profession and the public at the time of the 1966 meeting of the OSMA House of Delegates.

#### 1966 Conference on Medicine and Religion

The Council approved a statewide conference for county chairmen of Committees on Medicine and Religion sometime in 1966. It was requested that a tentative program be submitted to The Council for review before definite plans are established.

#### Mental Health Study Approved

The report on a meeting of the Ad Hoc Committee on Mental Hygiene Study of the OSMA Committee on Mental Health held on July 27, 1965, was approved.

#### Hospital Relations

The Council approved the minutes of the September 15, 1965 meeting of the Committee on Hospital Relations. This action included the approval of recommendations of the committee, which were amended to read as follows:

#### County Society Hospital Relations Committees

"(1) County Committees on Hospital Relations should function similar to the State Committee; (2) there should be a provision for the right of appeal and review from local to state level where action has been taken by a local hospital relations committee; (3) the State Committee should serve as a clearing house on information and developments in the area of hospital relations and communicate this information, as it becomes available, to local committees and that information should be funneled from local to state for evaluation, interpretation, dissemination and (4) chiefs of staff of hospitals, presidents and secretaries of county medical societies and physician members of boards of trustees should be alerted to the rights and responsibilities of physicians who provide the medical care in the hospital as affected by actions taken by the boards of trustees of hospitals."

#### OSMA-OHA Meeting on Medicare

An invitation from the Ohio Hospital Association with regard to a meeting of representatives of the OSMA and the OHA to discuss mutual areas of concern associated with Medicare was presented. The Council authorized President Crawford, with such OSMA representatives as he shall select, to meet

with the Ohio Hospital Association at such time as he deems appropriate.

### Emergency Room Payments

The Council approved the action of the Committee on Hospital Relations regarding emergency room payments and recommended to Ohio Medical Indemnity, Inc., that OMI give consideration to the payment of benefits as follows:

"Benefits under OMI contracts for professional services rendered in hospital emergency rooms should be limited to accident (accidental poisoning included) and bodily injury cases. Such services must have been rendered by a licensed physician and the bill must be submitted by a physician or somebody acting in his behalf. These benefits should be payable regardless of where the professional services are rendered."

### Physician Long-Term Facility Relations

With regard to a statement on physician long-term facility relations, the Council approved the committee's recommendations that the most plausible approach for operating a utilization review plan and developing medical care policies of long term care facilities would be a medical society based medical staff committee for an aggregation of nursing homes.

### Transfer of Medical Service Benefits to Blue Shield

Also approved in the report of the committee was its statement that it is proceeding with plans to arrange a meeting of three representatives each of the Ohio State Medical Association, Ohio Hospital Association, Ohio Medical Indemnity, Inc., and the Blue Cross Plans to discuss the removal of physicians' services from the category of hospital services in Blue Cross contracts.

### Health Facility Planning Committee

A communication dated September 17 from the president of the Ohio Hospital Association, in reply to Council action July 24-25 concerning medical representation on a proposed Coordinating Committee for Health Facility Planning, was considered. It was the decision of the Council that the Ohio State Medical Association participate, providing the OSMA representation under Class B of the committee structure is improved in addition to the increase to four OSMA representatives under Category C as mentioned in the communication of September 17.

### Measles Education Campaign

Mr. Gillen reported for the School Health Committee on a proposed measles education campaign. The Council endorsed the project and requested that it be discussed at the Councilor District Conferences; that the county medical societies be encouraged to promote the campaign; that it be stipulated that the

education campaign be administered and financed by the Ohio State Medical Association; and that the Ohio Medical Association seek joint sponsorship with the Ohio Newspaper Association.

### Maternal Health

Dr. Ruppertsberg presented the annual report of the OSMA Committee on Maternal Health, which was approved and accepted for publication in *The Ohio State Medical Journal*.

### National Foundation Prenatal Care Project

The Council also approved the minutes of the September 12th meeting of the Committee on Maternal Health, including the following recommendations on the National Foundation Prenatal Care Project:

"1. The members of the committee were in unanimous agreement with the purpose of any program which would improve patient participation in ideal prenatal care.

"2. The committee felt congenital defects per se were not predominantly linked to inadequate prenatal care of the patient, although congenital malformations may respectively give rise to premature delivery of the malformed fetus.

"3. The committee surmised that the program would fail to reach the low socio-economic bracket of patients. The committee reflected that the large percentage of illegitimate births were of mothers who had no prenatal care and were also indigent patients, mostly wards of welfare agencies.

"4. The committee believes that prevention of 'birth defects' (and congenital anomalies) comprised the smaller problem; a bigger one rests in establishing adequate prenatal care, protecting maternal health, preventing prematurity, etc. Members decried the employment of a 'scare technique' in promotion of a program designed to improve prenatal care.

"The committee further stated that activity of such a program should be directed first toward stimulation of prenatal patients to seek early, adequate prenatal care in the present local medical profession and in existing (clinical) installations. This preliminary step should be taken before establishing new (National Foundation) facilities.

"That the proposed project should be referred for study and advice concerning applicability to (a) OB-GYN societies in Cleveland, Columbus, Cincinnati, Dayton, Toledo and Akron; (b) respective Ohio county medical societies; and (c) the American College of Obstetricians and Gynecologists."

The Council adopted the recommendation of the committee as outlined above and requested that the statement be sent to county medical society presidents and secretaries; that it be discussed at the Councilor District Conferences; and that the OSMA Public



Relations Department prepare positive and constructive material pointing up the Ohio Medical profession's ongoing maternal health program covering this field, by telling of the work of the Committee on Maternal and Child Care of the American Medical Association, and by bringing attention to the inadvisability of using scare techniques in education programs.

### **Revisions in U. S. Birth and Death Certificates**

The Council amended the Maternal Health Committee's action with regard to revisions in the U. S. certificates of birth, fetal death, and death, and directed that the chief of the Division of Vital Statistics of the Ohio Department of Health be advised concerning the resulting policy, which reads as follows:

"The committee examined features of the present Ohio forms in comparison with the suggested proposed certificates of birth, death and stillborn. Several points on the proposed forms (developed by the Department of Health, Education, and Welfare) were deemed eligible for correction, addition or clarification:

"1. Death Certificate. (Heading) Is this form for all physicians, or for the coroner only?

"2. Birth Certificates. To what age fetus is this to be applied, e. g., over 500 grams (20 week gestation) or to include all embryos? Serology date and 'Apgar Score' of the newborn should be added in blank spaces at the bottom of the form.

"3. Certificate of Fetal Death. All items appear clear. It is essentially the same as the present form, except rearrangement has been accomplished.

"The committee noted the following features with reservation or objection:

"1. Death Certificate — The form (data rearranged) seems adaptable with alterations, but appears to be published only for use of the medical examiner or coroner.

"2. Live Birth Certificate — With additions (mentioned above) the form seems adaptable but present (hospital) administrative personnel are inadequate in number and knowledge to fill in all the data in the proposed lower 2/5 of the form. It was pointed out the certificates are public documents. Furthermore, members queried, 'Is this document to be an official certificate of birth for legal purposes, or is it a complex statistical information sheet?'

"3. Certificate of Fetal Death — The objections were the same as those listed above."

### **Centralizing Health Planning Information in Ohio**

Mr. Gillen reported on an Ohio Health Department application for a Federal research grant of \$133,025 to make a feasibility study of centralizing health planning information in Ohio. No action taken.

### **Revision of OSMA Pension Trust Program**

A proposal for the revision of the OSMA pension trust program was referred by The Council to the Committee on Auditing and Appropriations.

### **OMI Comprehensive Contract**

The Executive Secretary announced that 80 county medical societies have approved the Ohio Medical Indemnity comprehensive contract as of September 18, 1965.

### **Medicare Act - Blue Shield Problems**

Mr. Coghlan discussed problems of the Blue Shield in relationship to the passage of Public Law 89-97, the Medicare Act.

### **Tenure of Board Members of OMI**

The Council adopted the following guidelines concerning the tenure of the Board of Directors of Ohio Medical Indemnity, Inc.:

"1. The composition of the Board of Directors should remain as it is at the present. Very careful attention should be given by the Nominating Committee to see that the board has representation from as many different geographical areas throughout the state of Ohio as possible.

"2. The directors should continue to be elected for one year at a time, but no director should serve for more than ten successive years.

"3. The chairman of the Nominating Committee for the OMI Board of Directors should also serve on the Liaison Committee of the OSMA to OMI, Inc.

"4. It would be advisable to have all members of the Nominating Committee attend at least one meeting per year of the OMI Board of Directors.

"5. It is suggested that the changes as listed above be effective this year (1965) but shall not be retroactive. In other words, all current board members may serve an additional ten successive years or until the election of 1975. All members subsequently elected may serve for ten successive years starting with their date of initial election."

### **OMI Comprehensive Contract**

On the question of establishing one income ceiling only, to wit, an income ceiling of \$7,500 in connection with the Ohio Medical Indemnity comprehensive contract, The Council suggested that OMI obtain the consent of the county medical society, or societies, in the area where such policy is written with regard to the size of the ceiling or whether there should be any ceiling at all.

### **OSMA Group Life Insurance Plan**

The Council accepted for information a report from Turner & Shepard, Inc., Columbus, dated March 1, 1965, regarding the OSMA Group Life Insurance Plan administered by that agency. The report cov-

ered the period from September 1, 1964 to March 1, 1965.

The Executive Secretary was authorized to ask the Turner & Shepard Agency to explore the possibility of higher coverage made possible under provisions of Senate Bill 62 which was passed by the 106th Ohio General Assembly.

### OSMA Major Medical Insurance Plan

Mr. Dale Harrison, Insurance Company of North America, Philadelphia, and Mr. Spencer W. Cunningham of Daniels Head & Associates, Portsmouth, appeared before The Council to discuss developments concerning the operations of the major medical insurance plan and certain recommended changes made necessary by experience, as follows:

"A. The OSMA - Plan will pay up to \$15,000 per person for any one sickness or accident and all related conditions or recurrences. Payment in excess of the deductible is made on the following basis:

Eighty per cent (instead of 100%) of all eligible expenses while in hospital, sanatorium or nursing home. Eligible expense for room and board to be limited to \$30 per day (instead of no limit).

"B: The deductible of \$300, \$500, or \$1,000 is to be accumulated within six consecutive months (instead of twelve months).

"C. Benefit Period commences immediately on satisfaction of the deductible. It continues for three years, or until recovery or until the completion of any three consecutive months during which \$150 in Eligible Expenses have not been incurred (instead of the completion of six consecutive months during which no Eligible Expenses have been incurred), whichever occurs first.

"D. The OSMA-Plan will contain an offsetting provision for Basic Medicare - Hospital Insurance Benefits for those insureds age 65 and over, effective July 1, 1966. (Insurance industry actuaries are now measuring the dollar deductible value of Basic Medicare. This information will be available in about thirty days.) Any insured member who is or will be 65 before July 1, 1966, will be renewed on a six month mode (December 1, 1965 to June 1, 1966) at the rates shown in Exhibit I. At that time new rates (which will be submitted to OSMA and Daniels-Head and Associates for approval) which reflect the deductible value will be charged for those age 65 and over.

"E. Full time medical students, interns and residents attending accredited institutions in Ohio are now eligible for the \$500 deductible plan without underwriting if application is made during the first sixty days following enrollment in a medical institution. This is to be modified to permit only one sixty day enrollment to any one

individual, which would begin the first day he is enrolled as either a full time medical student, intern or resident in a medical institution."

By official action The Council voted to continue to sponsor the plan, including the above changes as recommended by the Insurance of North America with the provision that the top limit be raised from the present \$15,000 per person to \$20,000. The Council thanked the representatives of the Insurance Company of North America and the Daniels-Head Agency for their information and invited them to appear a year hence with a progress report.

### Travel Accident Insurance

A proposal for travel accident insurance covering officers, councilors, committeemen and the staff of the Ohio State Medical Association was referred to the Committee on Insurance for study.

### Ohio Medical Political Action Committee

The Executive Secretary reported on activities of the Ohio Medical Political Action Committee.

### Meeting of AMA Delegates and Alternates

Dr. Budd reported on the meeting of the AMA delegates and alternates, held September 17 preceding The Council session.

The Council approved the appropriation of \$500 for the business activities of the delegates and alternates, to be administered by the chairman.

The Council also approved the re-election of Dr. Budd as chairman, Dr. Petznick as vice-chairman of the delegation, and the endorsement of Dr. Robert E. Reiheld, Orrville, for membership on the AMA Council on Rural Health.

An action of the delegates, providing for obtaining "position papers" from candidates for AMA elective offices, was approved.

Council received for information a recommendation from the delegates that the Ohio State Medical Association promote the candidacy of Dr. Richard L. Meiling, Columbus, for high elective AMA office at the earliest appropriate time.

### Special Session of the AMA

The Council then discussed the special session of the AMA House of Delegates to be held in Chicago, October 2 and 3, 1965.

Upon the recommendation of Ohio's delegates and alternates to the American Medical Association, The Council directed support of a West Virginia State Medical Association resolution calling for the inclusion of Doctors Donovan F. Ward, Edward R. Annis and Amos N. Johnson on the AMA "Task Force."

The Council voted to request Ohio's alternate delegates to attend the AMA special session.

The following resolutions were approved by The Council for submission at the AMA Special Session on October 2 - 3:



### Non-Discrimination Pledges

WHEREAS, The Department of Health, Education and Welfare has attempted to force physicians treating patients under federally-assisted programs to sign pledges of non-discrimination, and

WHEREAS, Physicians, by subscribing to the Principles of Medical Ethics, willingly pledge to render service unconditionally to all patients with full respect for the dignity of man, providing for each a full measure of service and devotion, including in time of war the provision of medical care to the captured enemies of our country;

WHEREAS, These conditions willingly self-imposed by the medical profession far exceed any pledge of this nature demanded by a Federal bureaucracy;

NOW, THEREFORE BE IT RESOLVED, That all physicians are hereby informed that the refusal to sign such an oath does not flout the law; and be it further

RESOLVED, That the House of Delegates directs the Board of Trustees and the officers of this Association to oppose actively and forcefully this and any future attempts by HEW or any other Federal agency to impose conditions and pledges upon the medical profession.

### Relationship between the AMA and the Executive Branch of Government

WHEREAS, The House of Delegates in June, 1965, expressed the hope that the Executive Branch of Government would invite the representatives of the AMA to meet with, and consult on federal legislation and health programs and in recent weeks such meetings have, in fact, taken place; now therefore be it

RESOLVED, That the officers and Board of Trustees of the AMA be commended for the efforts made in the consultations held thus far and that continuation of such consultations, meetings and expressions of advice with and to the Executive Branch of Government be recommended, and that objectives be consistent with the policies and concepts expressed by the House of Delegates regarding health programs and legislation; and be it further

RESOLVED, That the reporting of these activities by the AMA Communications Division should stress the presentation by AMA representatives of programs and principles established by the House of Delegates thus reassuring the membership of the continued presentation of the philosophy of the medical profession at the highest levels of government.

### A Committee on the Development of Medical Legislation

WHEREAS, The several departments and agencies of the Executive Branch of government and the national non-governmental organizations have well established staffs continually engaged in developing future legislative proposals in the field of health activities; and

WHEREAS, The AMA does not, at this time, have an agency charged principally with the development of future legislation; now therefore be it

RESOLVED, (A) That the Board of Trustees establish a continuing Committee on Development of Medical Legislation, such proposed legislation to be consistent with the principles established by the House of Delegates;

(B) That the Board of Trustees shall adequately staff this Committee to enable it to accomplish its mission; and

(C) That the Committee shall have nine members, each appointed for a term of three years except that in 1965 three members of the Committee shall be appointed for one year, three for two years and three for three years. At time of appointment, at least five members of this Committee shall be named from the roll of delegates in the House of Delegates.

### Adherence to Established Principles

WHEREAS, The House of Delegates of the AMA has established certain general principles for Health Care legislation that would avoid a deterioration in the quality of

medical care and would be consistent with medical ethics, now therefore be it

RESOLVED, That these principles be the constant guidelines in use:

(1) By our representatives in their meetings with government,

(2) By the individual physician in making his decisions concerning his personal action with reference to health care legislation; and be it further

RESOLVED, That policies or actions based on these principles and taken by individual physicians or deliberating bodies acting for physicians have the united support of the medical profession and that its good offices be used in support of these physicians or deliberative bodies.

### Implementation of Public Law 89-97 as it Pertains To the Medical Care of Patients 65 Years of Age or Older

WHEREAS, The advice of the AMA given to the government and the public to the effect that the legislation now embodied in P.L. 89-97 was not medically, socially or economically sound and nothing has occurred to change this advice or philosophy, nevertheless P.L. 89-97 is now the law of the land and in its implementation the medical profession has an obligation to present to government and the public its best medical advice to:

(a) Assure to the patient superior care and treatment,

(b) Preserve the physician's professional integrity and rights as a citizen,

(c) Respect the obligations and responsibilities of the taxpayers;

NOW BE IT RESOLVED, That the following guides, but not necessarily limited thereto, be accepted as basic principles of the advice and consultation which the AMA representatives shall utilize in conferences with government personnel responsible for development and implementation of the administration of P.L. 89-97:

(1) The professional opinion of the responsible physician shall be the prevailing criterion in determining the professional care including hospitalization of a patient.

(2) In matters of co-insurance or implementation of other provisions of P.L. 89-97, the physician shall expect the patient to assume responsibility for payment of professional services rendered. The physician shall not become the arbitrator of relations between individual patients and the government nor shall he be expected to be the collector of the patient's remuneration from the government.

(3) Diagnostic, therapeutic and rehabilitative procedures should be authorized only as prescribed by physicians and based upon accepted scientific and medical professional criteria as differentiated from economic criteria.

(4) Full regard of patient needs, physicians rights and taxpayers obligations should be considered at all times.

(5) Physicians shall be entitled to reasonable remuneration as provided by P.L. 89-97 and this shall be interpreted as the individual physician's usual and customary fee for the care of private patients.

(6) The executive branch of government is enjoined in P.L. 89-97 from exercising any supervision or control over the practice of medicine. This concept is to be jealously guarded at all levels of administration.

(7) Government required forms and reports, to be prepared by physicians to implement this legislation, should be limited to the minimum consistent with providing superior patient care as differentiated from statistical studies, social evaluations, economic survey programs.

### State Medical Journal Advertising Bureau, Inc.

Mr. Moore reported on the progress of the *State Medical Journal* Advertising Bureau's campaign to build advertising revenues for the state journals.

### Associate Editors for The OSMJ

It was suggested that the appointment of associate editors from various areas of the state to assist in obtaining scientific papers be explored.

### OSMJ Editor Commended

The Executive Secretary presented correspondence from Dr. John H. Davis, program chairman, Ohio Chapter of the American College of Surgeons, commending Dr. Perry R. Ayres, Columbus, Editor of *The Ohio State Medical Journal*, on his work in updating the publication and offering cooperation in obtaining manuscripts.

### Ohio Medical Society Executives Association

The Council approved and commended the idea of the formation of a Medical Society Executive Secretaries Association.

The President, President-Elect and the Executive Secretary reported on the conference for Ohio Medical Society Executive Secretaries held August 17, prior to the AMA Public Relations Institute and the Medical Society Executives Association meeting in Chicago. Fourteen Ohio Medical Society Executive Secretaries attended the meeting, which was presided over by Mr. W. "Bill" Webb, Executive Secretary of the Columbus Academy of Medicine. The program was provided by the OSMA officers and executive staff, with resource personnel furnished by the American Medical Association. Dr. F. J. L. Blasingame, Executive Vice-President of the AMA, addressed the group. Arrangements were handled by Mr. Aubrey D. Gates, Director of the Field Division, and his staff.

### Committee Merger

The Council adopted a report which called for the combining of four committees, namely, Poison Control, Occupational Health, Radiation, and Traffic Safety, to form an OSMA Committee on Environmental and Public Health. The new committee would be concerned with the activities now assigned to the above four committees and with the addition of such problems as quackery, venereal disease, communicable diseases, immunization, voluntary health agencies, etc. The effective date of the transition was set for May 27, 1966.

### Joint Advisory Committee on Athletic Injuries

Minutes of the August 8th meeting of the Joint Advisory Committee on Athletic Injuries were approved as presented by Mr. Gillen. This included the approval of a plan outlined for the August, 1966, Postgraduate Institute on Athletic Injuries for Physicians.

### Workmen's Compensation

Mr. Edgar reported that the tentative time for the implementation of the "usual and customary fee

plan" by the Industrial Commission for Workmen's Compensation benefits would be early October, 1965.

### Subscriptions to *Today's Health*

The Council authorized the payment of funds to renew the subscriptions for *Today's Health* being sent to 37 Ohio colleges for use in their teacher training programs.

### Legislation

The Executive Secretary reported on current legislative proposals, including an attempt to obtain hearings this Fall on H. R. 10, introduced by Congressman Keogh, in order to provide needed amendments to the existing law governing pension arrangements for self-employed professional men. It was Mr. Page's opinion, based on conversations with legislators, that hearings on the bill will be delayed until the second session of the 89th Congress.

### Directors of Medical Education

The Council discussed proposals for the formation of an organization of hospital directors of medical education in Ohio. They voted to take steps to explore the formation of an OSMA Section for Hospital Directors of Medical Education.

### Proposed Vacation Package Plan

An offer from the American International Travel Service, Inc., Chestnut Hill, Massachusetts, regarding a proposed vacation package plan for OSMA members, was presented. The Council requested the Executive Secretary to indicate to the company that the Association is unable to accept the offer at this time.

### Hartman Theater Building

A letter to Dr. Crawford from Mr. F. Herbert Hoffman, Jr., Secretary of the Helena Corporation, owner of the Hartman Theater Building, was presented for information purposes. The communication was referred to the OSMA Future Planning Committee.

### Right of Physician to Choose Patients

A matter threatening the right of a physician to choose the patients he will serve, involving Dr. Nino M. Camardese, Norwalk, Huron County, was discussed by The Council. The Council voted to offer the support of the Ohio State Medical Association to the Huron County Medical Society in the issue involving Dr. Camardese, such support to include efforts of the officers, Councilors and the legal counsel of the Association.

There being no further business, The Council adjourned until the next meeting on December 11 and 12.

Attest: HART F. PAGE

*Executive Secretary*





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# Outstanding Scientific Exhibits At OSMA Annual Meeting

AT the 1965 Annual Meeting of the Ohio State Medical Association held in Columbus, 34 Scientific and Educational Exhibits were presented, and drew an unusual amount of interest from physicians. As previously recommended by the Committee on Scientific Work and approved by The Council, awards were authorized for a limited number of exhibits designated as outstanding by the judging committee. This year six exhibits were selected to receive the special honors which included mounted and engraved plaques, certificates and monetary awards. The committee designated three exhibits in the field of teaching and three in the field of original investigation to receive respectively the gold, silver and bronze awards. Following are brief descriptions of two of these outstanding exhibits with photographs on the facing page:

\* \* \*

## Exhibit on Lupus Erythematosus Honored in Teaching Field

The exhibit entitled "Clinicopathologic Spectrum of Cutaneous Lupus Erythematosus," sponsored by Drs. W. A. Hawk, K. H. Burdick, Faye A. Rundell, and J. R. Haserick, of the Cleveland Clinic Foundation, was presented the Bronze Award in the Teaching Field.

The presentation was based on histopathologic assessment of 1200 patients with this disease seen at the Cleveland Clinic since 1948. The exhibit showed how the cutaneous manifestations of lupus erythematosus had been clinicopathologically classified into 12 varieties. These 12 categories allow themselves to fall into an arrangement which demonstrates the curious clinical spectrum of this disorder ranging from the rather innocent, purely cutaneous manifestations to those associated with exacerbations of systemic lupus erythematosus.

The exhibit itself was divided into four panels, each with three of the lupus varieties. Each of the cutaneous lupus erythematosus was represented by a gross picture of the lesion with an appropriate photomicrograph. In addition, composite, pertinent clinical facts, salient gross and microscopic features, and features differentiating the various types were given.

The first panel included lupus erythematosus profundus, lymphocytic lupus erythematosus and "mixed" collagen types.

Panel two included discoid lupus erythematosus, hypertrophic discoid lupus erythematosus and bullous discoid lupus erythematosus.

Panel three contained disseminated discoid lupus erythematosus, scarring systemic lupus erythematosus and lupus erythematosus ulcers.

Panel four contained butterfly erythema, "lupus pernio" of Hutchinson, and recurrent, nodular, diffuse erythema.

## Force on Obstetrical Forceps Demonstrated in Exhibit

The Bronze Award in the field of Original Investigation went to the exhibit entitled, "Delivery Force: Traction and Compression Forces Exerted by Obstetrical Forceps and Their Effect on Fetal Heart Rate." The exhibit was sponsored by the following team members from the Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus: Drs. John C. Ullery, N. J. Teteris and Andrew W. Botschner, and Miss Betty A. McDaniels.

Under the caption, "How Hard Do YOU Pull on the Baby?" the exhibit showed by charts, sketches and descriptions the various results of studies on the forces exerted in the use of obstetrical forceps.

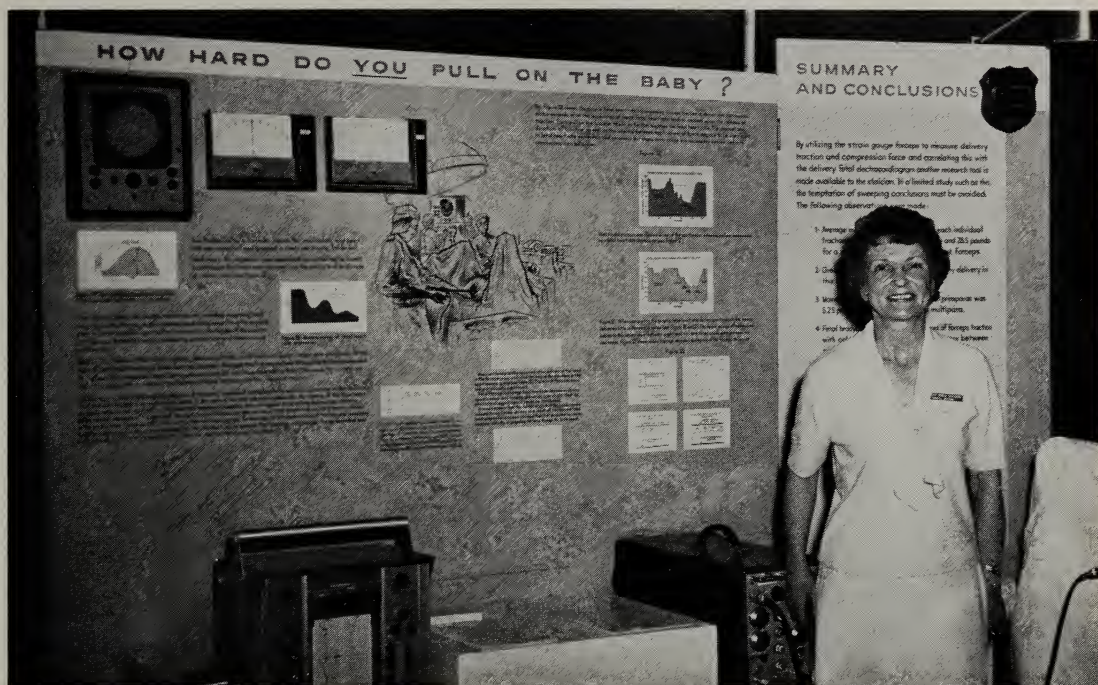
The main theme was a pair of forceps modified with strain-gauges and connected to electronic equipment for monitoring and recording compression and traction forces. The forceps were attached to a mannikin fetus and visiting physicians were invited to manipulate the equipment and receive actual recordings of pressures applied.

The research team drew some limited conclusions from their experience with this instrument, and recommended that additional studies be directed along these lines.

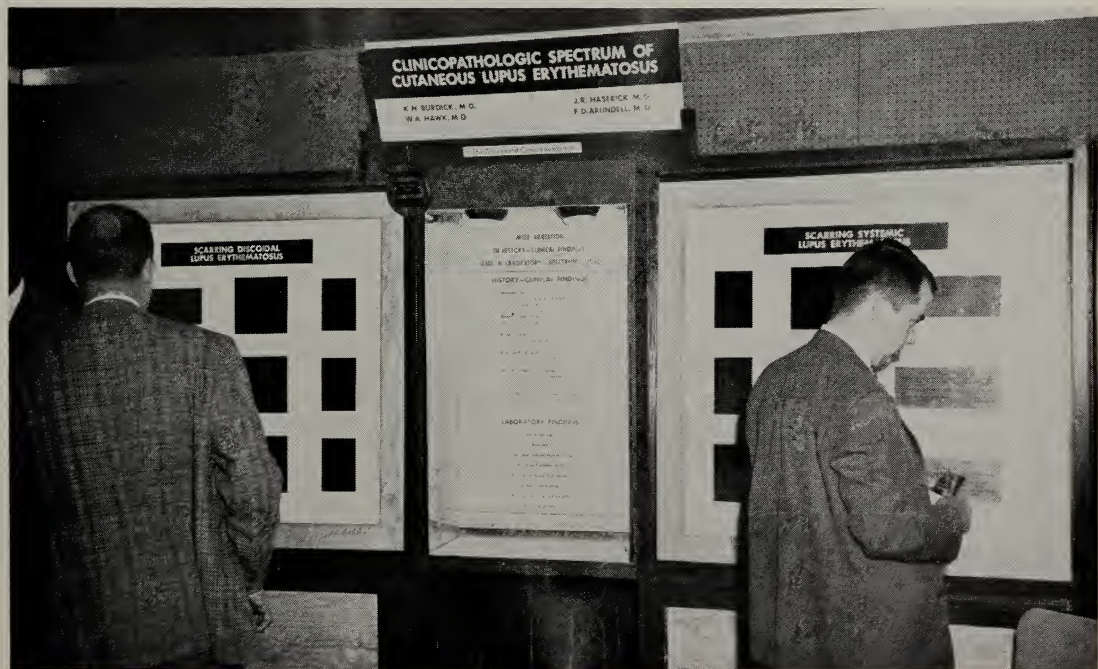
One of the noteworthy features of the exhibit was the report on relationship between fetal heart rate and pressure used in manipulation of the forceps. This phase of the study was well documented.



# Bronze Award Winning Exhibits



*This is the Bronze Award winning exhibit in the field of original investigation, entitled "Traction and Compression Forces Exerted by Obstetrical Forceps and Their Effect on Fetal Heart Rate," as shown at the 1965 OSMa Annual Meeting in Columbus. Manning the exhibit is Miss Betty McDaniels, a member of the sponsoring team from Ohio State University.*



*This exhibit, entitled "Clinicopathologic Spectrum of Cutaneous Lupus Erythematosus," won the Bronze Award in the teaching field at the 1965 OSMa Annual Meeting. The sponsoring team was from the Cleveland Clinic Foundation.*

# Preview of the 1966 Annual Meeting ...

State Association Meets in Cleveland, May 24-28;

Physicians Will Benefit from New Time Schedule

OHIO PHYSICIANS will find that the new time schedule for the 1966 OSMA Annual Meeting concentrates scientific events toward the latter part of the week, a more convenient arrangement as far as office and hospital timetables are concerned.

The Committee on Scientific Work especially had the busy schedule of doctors in mind when it set up scientific events for Wednesday afternoon, all day Thursday and Friday, and for Saturday morning. Top social event of the meeting, the President's Reception, is set for Friday evening.

Also in the making for the Annual Meeting is an excellent Scientific and Health Education Exhibit as well as the usual outstanding Technical Exhibit—always features of top interest to physicians and guests.

Following is the schedule in outline as recommended by the Committee on Scientific Work and approved at a recent meeting of The Council:

(All Events — Eastern Daylight Saving Time)

Tuesday, May 24

6:00 P. M.

Dinner for delegates, alternates, and OSMA Council, followed by first business session.

Wednesday, May 25

9:00 A. M.

Meetings of the House of Delegates Reference Committees.

10:00 A. M.

Registration Opens. Opening of Scientific, Health Education and Technical Exhibits.

1:30 P. M.

General Session — "Problems of Marriage."

Program sponsored by the OSMA Section on Psychiatry and Neurology and the Ohio Psychiatric Association and co-sponsored by all other OSMA Sections and the OSMA Committee on Medicine and Religion.

Ohio Health Commissioners — Meeting with Director of Health.

3:00 to 3:30 P. M.

Recess for Tour of Exhibits.

3:30 P. M.

General Session — "What I Do About It."

Sponsored by the Western Reserve University School of Medicine.

6:00 P. M.

Council dinner honoring past presidents.

Thursday, May 26

9:00 A. M.

Registration Opens. Tour of Exhibits.

9:00 A. M.

Executive Sessions of Reference Committees.

General Session — "Athletic Injuries."

Program to be presented by the Ohio Committee on Trauma, American College of Surgeons, the Joint Advisory Committee on Athletic Injuries of the OSMA and the Ohio High School Athletic Association.

10:30 A. M.

Recess for Tour of Exhibits.

11:00 A. M. to 12:00 Noon

Continuation of General Session Program.

1:30 to 2:30 P. M.

General Session — Secretary, U. S. Department of Health, Education and Welfare, John M. Gardner, Ph. D. (tentative)

2:30 to 3:00 P. M.

Recess for Tour of Exhibits.

3:00 to 5:30 P. M.

Sessions of Scientific Sections and Specialty Societies:

Section on Anesthesiology

Section on Internal Medicine and Ohio Society of Internal Medicine

Section on Psychiatry and Neurology and Ohio Psychiatric Association

Ohio Health Commissioners' Institute

Ohio State Surgical Association (tentative)

Ohio Academy of Medical History

Section on Ear, Nose and Throat

(Program Continued on Page 1014)



APPLICATION FOR SPACE, SCIENTIFIC AND HEALTH EDUCATION  
EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 1966 ANNUAL MEETING,  
SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 24 - 28

1. Title of Exhibit: \_\_\_\_\_

2. Name(s) of Exhibitor(s): \_\_\_\_\_

\_\_\_\_\_

Institution (if desired): \_\_\_\_\_

City \_\_\_\_\_

3. Do you have a built-in exhibit? \_\_\_\_\_

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

Charts and posters \_\_\_\_\_ Photographs \_\_\_\_\_ Drawings \_\_\_\_\_ X-rays \_\_\_\_\_

Specimens \_\_\_\_\_ Moulages \_\_\_\_\_ Other material \_\_\_\_\_

(Describe)

6. Booth Requirements:

Amount of wall space needed? \_\_\_\_\_

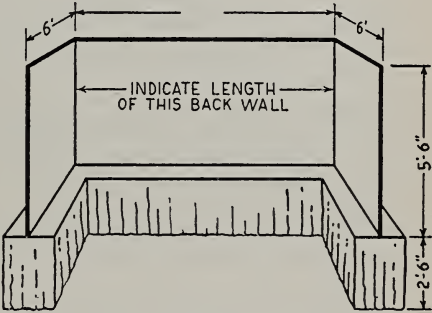
Back wall \_\_\_\_\_ Side walls \_\_\_\_\_

Square feet needed? \_\_\_\_\_

Shelf desired? (yes or no) \_\_\_\_\_

7. Transparency Cases:

Needed? (yes or no) \_\_\_\_\_



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Mailing Address, Street \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND HEALTH EDUCATION EXHIBITS,  
OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS, OHIO 43215  
DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1966

Friday, May 27

9:00 A. M.

Registration Opens. Tour of Exhibits.

9:00 A. M.

Final business session of House of Delegates.

9:00 to 12:00 Noon

Booth Seminars

Practical medical demonstrations of the following:

"Conditioning, Prevention and First Aid for Athletic Injuries"

"Bedside Pulmonary Function Testing"

"Resuscitation"

"Fractures"

"Physical Medicine in the Home"

"Lacerations"

1:30 P. M.

General Session — "Care of the Patient: 1966," to be presented by Dr. Edward R. Annis, Past President, American Medical Association.

2:30 - 3:00 P. M.

Recess for Tour of Exhibits.

3:00 to 5:30 P. M.

Sessions of Scientific Sections and Specialty Societies:

Section on Neurological Surgery and Ohio Neurosurgical Society

Sections on General Practice, Obstetrics and Gynecology, Pediatrics, and Ohio Chapter, American Academy of Pediatrics (combined).

Section on Occupational Medicine

Section on Physical Medicine and Rehabilitation

Ohio Society of Physical Medicine and Rehabilitation

Section on Orthopaedic Surgery and Ohio Orthopaedic Society

Section on Radiology and Ohio Chapter, American College of Chest Physicians

Section on Pathology and Ohio Society of Pathologists

Ohio Health Commissioners' Institute

3:00 P. M.

Exhibits Close.

6:00 P. M.

The President's Reception.

8:00 P. M.

Specialty Section and Society Dinners.

Saturday, May 28

9:00 A. M.

Registration.

Conference on Laboratory Medicine.

Annual Meeting Closes — 12:00 Noon.

## Radiologists' Statement on Separate Billing

The American College of Radiology has issued a statement in regard to separation of professional fees from hospital charges. Following is a "Summary — Policy Statement on Separate Billing," received in a communication from Jackson B. Livesay, M.D., Chairman, Board of Chancellors, of the College:

"1. It is the policy of The American College of Radiology that the members of the College shall separate their professional fees from hospital charges and present their own bills to all patients expected to pay for services.

"2. Because the Congress established in the medicare law, PL 89-97, provisions covering radiology solely as a medical service, and in response to the College's urgent request and that of the American Medical Association, radiologists have an obligation to make that portion of the program work as written.

"3. In establishing a separate billing procedure, radiologists should set their fees according to the worth of their professional service, but must guard against abuses which would significantly increase the cost to patients or their insurers.

"4. The radiologist shall not use a hospital as a billing agent. The radiologist may not ethically agree to pool his professional collections with hospital receipts. Exceptions to this recommendation are hospital based radiologists in group practice such as in a university medical school, in which all types of full time physicians practicing in a hospital voluntarily and mutually agree on a different arrangement. He may accept a salary from a hospital for administration, teaching or research, or the care of non-paying patients.

"5. Radiologists will need to enlist the aid of local medical organizations and explain their intent and reasons to insurance carriers and hospital boards to gain acceptance of separate billing.

"6. Appointment of radiologists to a hospital staff should be based upon the same criteria of personal competence and need for service as used for other members of the medical staff.

"7. Much tact, determination and patience will be required to bring about acceptance of separate billing by hospitals. However, the obligation of current physicians to preserve the status of the specialty within medicine makes the effort imperative."

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## Fifty Year Club

Physicians interested in the Fifty Year Club of American Medicine are invited to write to the secretary, J. H. McCurry, M.D., Cash, Arkansas 72421. Initial fee is \$5, used principally to defray expenses of button, certificate and tie bar or clasp.

The organization will hold a luncheon in Chicago at the time of the American Medical Association Annual Convention in June, 1966.



# To Participate Is Physician's Choice . . .

Special Session of AMA House of Delegates, October 2-3

Confirms Right of Individual Physician to Make Choice

THE American Medical Association's House of Delegates, meeting in Special Session in Chicago, October 2-3, voted to reaffirm the Association's position that whether or not to participate in the Medicare program (Public Law 89-97) is the individual physician's own choice.

OSMA delegates took a leading role as the House reaffirmed certain principles physicians may use in determining their attitudes toward health care legislation. These include the Bauer Amendment; the Nine Principles for Standards of Health Care Programs and Section Six, Principles of Medical Ethics. At the same time, the House rejected resolutions which proposed that the AMA support or urge nonparticipation in the program.

Further, the House of Delegates voted to continue to have representatives of the AMA meet with members of Federal Government agencies and departments for the purpose of developing regulations under the law which will help achieve medicine's objectives in behalf of the public and the profession. However, the House reminded those engaged in negotiations with the Federal Government to observe the principles adopted by the House when engaged in such negotiations.

## Reference Committee

Some 125 witnesses spoke before the Reference Committee on Legislation and Public Relations, to which all of the 43 resolutions were referred. Seven and one-half hours of testimony was heard by the Committee composed of Drs. B. E. Montgomery, Illinois, Chairman; George W. Petznick, Ohio; George J. Lawrence, Jr., New York; Harvey Renger, Texas, and John M. Rumsey, California.

The AMA's Special Legal Counsel, Mr. A. Leslie Hodson, Chicago, told the Reference Committee that organized medicine is free to urge repeal or modification of the Medicare Act, or to induce the U. S. Department of Health, Education and Welfare to adopt regulations under the Act that are more acceptable to the medical profession, but that no medical group, national, state or local, can legally "use such words as urge, advise, or advocate" in trying to promote nonparticipation. An organized effort of this nature would be in violation of the Sherman Anti-Trust Act, according to Mr. Hodson.

## Ohio Delegation Active

The House of Delegates recorded again its opposition to any legislation of the King-Anderson type.

Moreover, on the initiative of the Ohio Delegation, the House reaffirmed Section Six of the *Principles of Medical Ethics*, The Bauer Amendment and the Nine Principles of Standards of Health Care Programs. These principles and standards were approved as measuring sticks for use by the individual physician in determining his attitude and actions with regard to health care legislation and laws.

### (A) Principles of Medical Ethics, Section Six:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

### (B) The Bauer Amendment:

"The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

"The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

"The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest; and that it will not be a party to implementing any system which we believe to be detrimental to the public welfare."

### (C) Nine Principles For Standards of Health Care Programs

"(1) No person needing health care shall be denied such care because of the inability to pay for it.

"(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

"(3) Every level of government, municipal, county,

state and federal, should assume a responsible share in the financing of such programs.

"(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.

"(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

"(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

"(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

"(8) Any such health care programs should provide funds only, and not direct services.

"(9) Funds for such programs may come from general tax revenues and not from social security taxes."

The Ohio Delegation originally submitted the Nine Principles at the February, 1965 Special Session of the AMA House, and they were adopted at that time.

### Pledge of Compliance

On a motion by Dr. John H. Budd, Cleveland, Chairman of the Ohio Delegation, a resolution submitted by Ohio, relative to pledges of non-discrimination, was substituted for the policy statement recommended by the Reference Committee. The resolution is printed below:

"Whereas, The Department of Health, Education and Welfare has attempted to force physicians treating patients under federally-assisted programs to sign pledges of non-discrimination; and

"Whereas, Physicians, by subscribing to the *Principles of Medical Ethics*, willingly pledge to render service unconditionally to all patients with full respect for the dignity of man, providing for each a full measure of service and devotion, including in time of war the provision of medical care to the captured enemies of our country; and

"Whereas, These conditions willingly self-imposed by the medical profession far exceed any pledge of this nature demanded by a Federal bureaucracy; therefore be it

"Resolved, That all physicians are hereby informed that the refusal to sign such an oath does not flout the law; and be it further

"Resolved, That the House of Delegates directs the Board of Trustees and the Officers of this Association to oppose actively and forcefully this and any future attempts by HEW or any other Federal agency to impose conditions and pledges upon the medical profession."

### Utilization Review Committees

Although there were differences of opinion expressed as to the purpose of utilization review committees, there was general agreement with respect to the

composition of such committees. The House, accordingly, adopted the following statement of policy:

"Hospital utilization review committees shall be composed of practicing physicians."

### Accepted for Information

In response to a request for an opinion by the Speaker of the AMA House, the Judicial Council, on October 1, 1965, rendered the following opinion:

"The *Principles of Medical Ethics* are applicable to physicians when they engage in group action as well as when they act individually. Section 4 calls upon physicians to observe all laws. Accordingly, medical organizations must be mindful of the possible consequences of the actions they propose, engage in or encourage.

"Under ordinary circumstances, the individual physician acting independently, is ethically free to select his patients. (See Section 5 of the *Principles*.)

(a) He may decline to render medical services to persons covered by the "Health Insurance for the Aged Act." (b) He may choose to treat such persons without charge. (c) He may treat patients with the advance understanding that he will look to them exclusively for payment and that he will or will not in any way help them in obtaining reimbursement for the cost of his services or the cost of associated services.

"However, under some circumstances, the physician's freedom to select his patients may be circumscribed by overriding ethical considerations. For example:

"1. A physician should respond to any request for his assistance in an emergency.

"2. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice sufficient to allow the patient to obtain another physician.

"3. If a physician decides not to participate in the Medicare program or decides to limit his participation, he should so advise the patient in advance of treatment. This applies to services rendered by the physician as well as hospital services and other benefits provided under the program.

"4. As provided in Section 1 of the *Principles of Medical Ethics*, a physician should not refuse to render medical services to any person if as a result such person will be unable to get necessary medical care.

"It should be noted also that Section 6 of the *Principles* provides that 'A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause the deterioration of the quality of medical care.' If after regulations are promulgated and the Medicare law becomes effective, the individual physician acting independently and not in concert with others, finds it does tend to impair the free and complete exercise



of his medical judgment and skill or to cause a deterioration of the quality of medical care, the individual physician would be justified under this Principle in not participating under the law. The physician is ordinarily free to select his patients, subject to such ethical limitations as previously stated in Section 6 of the *Principles of Medical Ethics*, the Bauer Amendment, and in keeping with the nine principles for standards of health care programs adopted A-1965."

In accepting the Judicial Council's opinion, as reported by the Reference Committee, the House called attention to the fact that this opinion should be read together with the Bauer Amendment (A-1961) and the nine principles for standards of health care programs adopted A-1965; and that these two items be distributed with the Judicial Council's opinion on the ethics involved in physician participation or non-participation in the Health Insurance for the Aged Act.

Further, the following policy statement, relative to physician - patient relationship, was adopted.

"The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97."

#### Regulations Under Public Law 89-97

It was clear from the testimony received by the Reference Committee that the medical profession has a vital interest in the regulations which are to be promulgated under Public Law 89-97. "Hastily drawn, unrealistic regulations could aggravate even further the undesirable effects of this law." The House adopted the following statements as the present position and policy of the American Medical Association:

##### I. General.

"(a) The American Medical Association shall continue to meet with representatives of agencies and departments of the Federal Government, to participate in such advisory committees which are created, and to contribute whatever advice and suggestions are deemed advisable and necessary in the formulation and revision of regulations which will help it achieve Medicine's objectives on behalf of the public and the profession.

"(b) The American Medical Association urges every physician, regardless of the extent of his involvement, to render whatever advice and assistance he can so that regulatory changes and/or legislative modifications may be suggested or sponsored by the American Medical Association in order that the best interests of the public and the profession may be protected in the provision of medical care.

"(c) This House of Delegates expresses confidence in the Board of Trustees of the American Medical

Association, its Advisory Committee, and the three-man Consultant Committee on Public Law 89-97 for their continuing efforts to secure regulations which are in the best interests of good patient care."

##### II. Certification by Physicians.

"Current practices and customary procedures with respect to certification for hospital admission and care shall be continued under Public Law 89-97. The AMA Advisory Committee and the Association representatives to the technical advisory committees are advised to seek to accomplish this objective."

##### III. Blue Shield as Intermediary.

"Blue Shield has, in many areas, demonstrated its ability to provide a competent insurance program. However, the AMA should leave to the state or appropriate local medical society, as the case may be, the expression of any preference for selection of a carrier."

##### IV. Reasonable Fees.

"In the event of a dispute between physicians and carriers with respect to reasonable, customary, or usual fees, such disputes shall be resolved with the participation of the appropriate local medical society."

#### Separation of Professional Fees And Hospital Charges

The following statement of policy, which is self explanatory, was adopted by the House:

"Hospital - based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians. The American Medical Association intends to continue vigorously its efforts to prevent inclusion in the future of the professional services of any practicing physician in the hospital service portion of any health care legislation."

#### Ohioans Attend Meeting

Attending the Special Session were OSMA President, Dr. Henry A. Crawford, President-Elect, Dr. Lawrence C. Meredith and the following members of the Ohio Delegation: Drs. John H. Budd, George W. Petznick, Carl A. Lincke, Theodore L. Light, Edmond K. Yantes, Richard L. Meiling, Frederick P. Osgood, Charles A. Sebastian and Edwin H. Artman, all Delegates; and Alternate Delegates Drs. Robert S. Martin, Harry K. Hines, P. John Robeck, Robert E. Tschantz, J. Robert Hudson and Philip B. Hardymon.

Staff personnel attending the Special Session included Hart F. Page and W. Michael Traphagan, OSMA; Robert A. Lang, Cleveland; Edward F. Willenborg, Cincinnati, and Robert F. Freeman, Dayton.

# Support for Medical Education . . .

## Ohioans Again Offered Opportunity To Help Keep Medical Students and Medical Schools Independent and Solvent

OHIO's annual campaign in behalf of the Medical Education Loan Guarantee Program and the Funds for Medical Schools Program of the American Medical Association Education and Research Foundation is now underway.

Dr. Robert S. Martin, Zanesville, is Chairman of the Ohio AMA-ERF Committee, which is composed of the chairman and the 11 District Councilors of the Ohio State Medical Association.



Since 1951, when the AMA established its Funds for Medical Schools Program, members of the profession have contributed an average of more than a million dollars a year through this channel. Four times this amount is contributed annually by physicians directly to the nation's medical schools.

Grants to Ohio's three medical schools resulting from 1964 contributions to the Funds for Medical Schools Program were: Ohio State University College of Medicine, \$17,347; University of Cincinnati College of Medicine, \$17,244; Western Reserve University School of Medicine, \$18,964.

### School May Be Specified

Money contributed to AMA-ERF Funds for Medical Schools may be designated for a specific school by the donor or for medical education in general. In the latter case, funds are distributed equally among the medical schools. Deans of the medical schools may use Foundation grants at their discretion for special projects or expenses outside of their budgets.

The Medical Education Loan Guarantee Program, administered by AMA-ERF, guarantees long-term bank loans to medical students, interns and residents for essential training and living expenses. Each \$100 that is contributed to this Program, secures a loan of \$1,250. Some 22,000 loans have been made since this Program was initiated in March, 1962, totaling 33 million dollars.

Prior to this program's start, there was no adequate loan source readily available to medical students. In

plans which were available, rates were high and deferred repayment usually could not be arranged. Now a medical trainee may borrow up to \$1,500 per year over his training period to a total of \$10,000. He defers repayment until five months after completion of all his full time training, and then may take ten years to repay in monthly installments. Contributions to this program may be earmarked to guarantee loans in a particular state or area.

### Last Year Response Good

Last year more than half of the members of the Ohio State Medical Association made contributions to medical education, either through AMA-ERF or directly to their own schools.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Martin, members of the 1965 Ohio AMA-ERF Committee and the local chairmen urge Ohio physicians to respond generously in this year's campaign.

### Dr. Platter Honored for Unique Insurance Achievement

Dr. Herbert M. Platter, venerable secretary of the State Medical Board of Ohio, chalked up another record recently in his long list of achievements. He was honored as one of the exceptional individuals to outlive actuarial tables of the insurance companies.

Dr. Platter was "king for a day" at a luncheon in Columbus sponsored by the Ohio State Life Insurance Company and attended by several dignitaries, including Supreme Court Judge C. William O'Neill, Columbus Mayor Jack Sensenbrenner, Charles Werner, chief actuarial for the State Department of Insurance, and Dr. John A. Prior, Associate Dean of Ohio State University College of Medicine.

The insurance policy he surrendered for its face value plus dividends was purchased in 1907. Dr. Platter, who is still working daily, was 96 years old on last June 18.

A National Foundation grant of \$33,612 is promoting a project at the University of Cincinnati Medical Center under which the relationship between German measles and birth defects is being studied. Dr. Gilbert M. Schiff, assistant professor of medicine and microbiology, is chief investigator.



# Postgraduate Programs in Ohio . . .

Here Are Reminders on Programs Previously Announced  
And Additional Information on Other Meetings in the State

THIS is a follow-up on postgraduate programs held in various areas of the State, with additional information about programs announced to *The Journal* before this issue went to press. Numerous postgraduate programs were conducted during September and October, as indicated by announcements in the September and October issues.

\* \* \*

## Lectures on Human Reproduction Scheduled in Cleveland

The Institute for the Study of Human Reproduction, in association with the Saint Ann Hospital, Cleveland, presents "New Horizons in Reproductive Physiology and Pathology Lecture Series No. 4," November 8-10, in the building of the Academy of Medicine of Cleveland, 10525 Carnegie Ave.

(See program in October issue, page 926.)

\* \* \*

## Areawide Facilities Planning Institute — Columbus

An Institute on Voluntary Areawide Health Facilities Planning is scheduled at the Sheraton-Columbus Motor Hotel, Gay and Third Streets in downtown Columbus, on Sunday, November 7. Time is from 9:30 a.m. to 3:30 p.m.

Sponsors are the Ohio State Medical Association, Ohio Hospital Association and Ohio Osteopathic Association of Physicians and Surgeons. Reservations are being made through the Ohio Hospital Association, 40 South Third Street, Columbus.

(Refer to October issue, page 930 for details.)

\* \* \*

## Management of Gynecologic Cancer Symposium at Saint Luke's

Saint Luke's Hospital, Cleveland, Division of Obstetrics & Gynecology, will present a symposium, "Modern Trends in the Management of Gynecologic Cancer," in Saint Luke's Hospital during the afternoon and evening of Monday, November 29.

All interested physicians in the Northeast Ohio area are invited to attend.

Communications may be addressed to: Wendall W. Adams, M.D., Department of Obstetrics, Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland, Ohio 44104.

(Additional data, page 929, October issue.)

## Northwestern Ohio Program Findlay, November 11

The Northwestern Ohio Medical Association has announced its program for the 120th annual meeting, to be held at the Findlay Country Club, Findlay, Thursday, November 11. Registration begins at 9:30 a.m. with the first program feature at 10:00 o'clock. The organization is composed of physicians of the Third and Fourth Councilor Districts.

A team of physicians from the Cleveland Clinic staff will present the program as follows:

### Morning Program

Anemia in Gastrointestinal Disease, Dr. Richard G. Farmer, Department of Gastroenterology.

Short Circuiting for Weight Reduction and Hypercholesterolemia, Dr. Rupert B. Turnbull, Department of General Surgery.

Medical Treatment for Complicated Peptic Ulcer, Dr. Charles H. Brown, Department of Gastroenterology.

Results of Surgery for Duodenal Ulcer; Choice of Operation, Dr. Stanley O. Hoerr, Department of General Surgery.

Panel — What About Gastric Ulcer? Moderator, Dr. Brown.

Luncheon — Acknowledgments and Election of Officers.

### Afternoon Session

Medical Aspects of Ulcerative Colitis, Dr. Farmer.  
Surgical Treatment of Ulcerative Colitis, Dr. Turnbull.

Present Status of Gastric Cancer, Dr. Hoerr.  
The Nervous Patient and His Gastrointestinal Tract, Dr. Brown.

Panel on Colon Lesions, Moderator, Dr. Turnbull.

\* \* \*

## Columbus Academy Announces Specialty Day Program

Dr. Peter H. Knapp, professor of psychiatry, Boston University School of Medicine, will be guest speaker for the annual Specialty Day program on Monday, November 15, presented by the Academy of Medicine of Columbus and Franklin County and specialty societies of the area.

Cosponsors of the program dealing with emotional aspects in treatment of the patient are the Columbus

Ob-Gyn Society, the Neuropsychiatric Society of Central Ohio, and the Central Ohio Academy of General Practice.

Physicians outside of Franklin County who are interested in attending this program are invited to contact the Academy for arrangements.

\* \* \*

## Community Health Care Symposium Sponsored in Mahoning County

The Mahoning County Medical Society is sponsoring a "Community Health Care Symposium" on Thursday, November 11, under direction of the Areawide Hospital Planning Committee. The program will begin at 9:30 a. m. at the Mural Room and conclude at 5:00 p. m.

Topics for discussion will include, availability of medical facilities, problems of medical personnel, problems of rising health care cost and the role of the third party.

Luncheon speaker will be Dr. J. Everett McClenahan, medical director, McKeesport (Penna.) Hospital, whose topic will be "Hospital Utilization."

Additional information may be obtained from the Mahoning County Medical Society, 245 Bel - Park Bldg., 1005 Belmont Ave., Youngstown.

## Ohio Physicians Participate In National AHA Program

A number of Ohio physicians participated in the program of the American Heart Association which met recently in Bal Harbour, Florida, according to the program released shortly before the meeting.

One of the leading features was presentation of a report on an investigation made at the Cleveland Clinic in regard to certain items of diet in relation to levels of cholesterol in the human blood. Irvine H. Page, M. D., took a leading role in the investigation with Helen B. Brown, Ph. D., and Marilyn Farrand, Ph. D. This team also presented an exhibit on the same subject.

Dr. John A. Rogers, Youngstown, President of the Ohio State Heart Association, served as a resource consultant on medical complexes in the foregoing panel.

Dr. James V. Warren, Chief of the Department of Medicine at Ohio State University, and a past-president of AHA, was chairman of a panel of the Assembly on the subject of medical complexes as related to the President's Commission on Heart Disease, Cancer, and Stroke.

Dr. Richard W. Watts, Cleveland, past-president of the Heart Association of Northeastern Ohio, participated on a panel on "Staff-Volunteer Relationships," at a conference of professional workers.

Dr. F. A. Simeone, Cleveland, was co-chairman of a session on cardiovascular surgery.

The following physicians of Cleveland participated on a panel entitled "Active Physical Reconditioning

of Coronary Patients": Drs. Herman K. Hellerstein, Alfred G. Burlando, Eugene Z. Hirsch, Franklin H. Plotkin, George H. Feil, and Neil Margolis.

Drs. William L. Proudfit, Earl K. Shirey and F. Mason Sones, Jr., of the Cleveland Clinic staff, presented papers during a clinical session on "Selective Coronary Cinearteriography in Angina Pectoris and Myocardial Infarction — Distribution of Obstructive Lesions."

Dr. Donald B. Effler, Cleveland, participated in a symposium on "Surgical Treatment of Coronary Artery Disease."

Drs. Jay L. Ankeney, Laurence H. Coffin, and Edward M. Beheler, all of Cleveland, presented papers in a cardiovascular surgery session on the subject "Experimental Study and Clinical use of Epinephrine for Treatment of Low Cardiac Output Syndrome."

Drs. Ernest H. Friedman and Herman K. Hellerstein, both of Cleveland, spoke during a session on arteriosclerosis.

Drs. Edward D. Frohlich, Robert C. Tarazi, Harriet P. Dustan and Irvine H. Page, all of Cleveland, discussed a tilt test for investigating a neural component in a session on hypertension.

Drs. Ray W. Gifford, Jr., and Lawrence J. McCormack, Cleveland Clinic, presented results in 45 patients with unilateral renal atrophy who had undergone nephrectomy for hypertension.

Dr. Harriet P. Dustan, Cleveland Clinic, co-chaired a session on hypertension, in which the following other Cleveland physicians took part: Drs. Simon Koletsky, Jose M. Rivera-Velez and Walter H. Pritchard.

Dr. Oscar D. Ratnoff, Cleveland, delivered a lecture on "Modern Concepts of Thrombus Formation."

Participating in a series of cardiovascular conferences on specific problems were the following Cleveland physicians: Dr. Herman K. Hellerstein, cardiac arrhythmias; Dr. Harriet P. Dustan, and Dr. F. Merlin Bumpus, angiotensin assays in treatment by hypertension; Dr. Victor G. deWolfe, treatment of peripheral vascular diseases; Dr. John J. Cranley, Jr., and Dr. Salvatore M. Sancetta, pulmonary embolism; and Dr. Laurence K. Groves.

Dr. Walter H. Pritchard, Cleveland, was co-chairman of a clinical session on cardiac arrhythmias.

Dr. Jay L. Ankeney, Cleveland, was chairman of a session in which six new medical films were shown.

Drs. Noble O. Fowler and John C. Holmes, Cincinnati, presented the topic, "Pulmonary Artery Pressure at High Rates of Pulmonary Blood Flow."

Dr. Arnold M. Weissler, Columbus, was co-chairman of a session on neuro-hormonal control.

Dr. William B. Leffler, Marion, presented a paper on "Anatomical Base of a Case of Wolff-Parkinson-White Syndrome Terminating in Complete Atrioventricular Block."



# Public Health in Ohio ...

## State Health Director Reviews Activities in Health Field Before Annual Meeting of Health Commissioners

A FEATURE of the Conference of Ohio Health Commissioners held in mid-September was the report presented by Dr. Emmett W. Arnold, director of the Ohio Department of Health. The 46th annual conference was held in the Christopher Inn, Columbus.

Following are excerpts of Dr. Arnold's talk:

In general the health of Ohio is good; communicable diseases are well under control; no epidemics or major outbreaks of infectious diseases have been experienced.

At the extremes of life — for the very young and for the aged — public health services and protection have been improved.

Inadequate immunization of a rapidly multiplying population offers a constant threat.

For the very young and for the elderly technically improved methods for screening those who need special medical attention have been devised, but improvement is needed in this field.

The Ohio General Assembly has passed and the Governor has signed into law an array of bills which will vastly broaden the authority and greatly extend the responsibilities of public health agencies.

### Subsidy for TB Patients

For a stronger attack on tuberculosis, there is a new law which will double the state subsidy for patients, at the same time giving authority to designate qualified hospitals where this subsidy may be paid. This law further requires the establishment of tuberculosis registries in each county so that there may be a truly complete statewide record. Other sections of this law encourage the creation of more local tuberculosis clinics, essential both to augment case-finding programs and to provide adequate follow-up care after hospitalization to avoid relapse of patients.

Another law aimed at eliminating one form of mental retardation requires the testing of each newborn infant for the presence of phenylketonuria, or PKU.

There is a new law with respect to the inspection, licensing and supervision of nursing and rest homes. It clarifies responsibility, and is designed to tighten

administration and enforcement of nursing home laws and regulations and to eliminate duplication of inspections and fees.

Amendments were made in state laws having reference to the federal Hill-Burton Hospital Construction Act, which will enable Ohio to continue receiving some \$10 million a year in grants. Composition of the state's Hospital Advisory Council is changed to conform with recent amendments to the Hill-Burton Law. The Ohio Department of Mental Hygiene and Correction is designated as the sole agency to administer the statewide plans required as a condition of receiving federal assistance under the Community Mental Health Centers Act and under Part C of the Mental Retardation Facilities Construction Act.

### Alcoholism Programs

New legislation assigns one-half of one per cent of the undivided liquor permit fund together with an equal amount from the state general fund for use by the State Department of Health to assist in the development of alcoholism programs.

In the field of environmental health, a new uniform statewide law governs the sanitary production, transportation and processing of fluid milk. Administration and enforcement is by local health departments, approved by the State Department of Health. A milk sanitation board also is established.

Another law extends food service licensing and inspection to cover baked goods and frozen desserts to avoid an area of duplication with the State Department of Agriculture. An amendment authorizes prosecution of an alleged violator of the food service law in any court of record.

The Division of Sanitation with aid from the Food Service Advisory Board has reviewed and updated the food service guide.

### Impact of Federal Programs

The impact of new federal legislation on public health is beginning to be felt. Such programs as Economic Opportunity and Appalachia are opening opportunities for additional public health facilities and programs. The Social Security Amendments

of 1965 will have an effect on public health as it will on health and medicine in general.

There is little doubt that some of the home care privileges included in the Social Security program can best be provided at this time through existing local health agencies which have developed home nursing care, therapy and rehabilitation programs. The fact that Ohio already has legislation which permits public health departments to accept fees for such services probably means that this state can move more easily into the new program.

Over 20 of the special projects in Ohio now being supported in part by the U. S. Public Service through the Chronic Disease Division have been aimed toward demonstration of nursing care at home, utilizing auxiliary nursing personnel, as well as development of coordinated home care programs.

Another certainty is that all public health chronic disease programs will expand rapidly in the years just ahead, especially those related to screening and early detection of illness.

Chronic disease programs in Ohio have been stepping up. An example is diabetes detection in which screening activities of public health departments reached only 2,605 in 1960 and were increased to more than 20,000 last year. Now the rate is about 35,000 a year.

New federal legislation in the field of maternal and child health provides funds for a variety of additional programs. A grant of more than \$1,300,000 recently was made to Cleveland for a special maternal and infant care project. Cincinnati is planning a similar project.

#### Aid for Children

The Division of Maternal and Child Health has been working on a program for children with communication handicaps in cooperative arrangement with the State Division of Special Education and the Crippled Children's Services. Local health departments reported that more than 1,376,000 children were screened last year for both hearing and visual defects, and that slightly over seven per cent were found to have problems.

Referrals are made either to private physicians or to Pediatric Otological Diagnostic Centers.

Additional Pediatric Otological Diagnostic Centers will be opened in the next year, making services available to 69 counties. Plans also are in the making for a projected auditory screening project for infants 8 to 14 months of age. Last year the Department conducted 37 workshops on audio-visual screening programs, attended by 116 nurses, 193 volunteers and 6 technicians.

In reference to communicable diseases, every effort should be made to encourage the use of measles vaccine.

The effect of polio vaccines, administered on a mass basis, has been nothing short of miraculous.

Only two cases of polio were recorded last year, and none so far this year. Every effort must be made to continue programs of polio immunizations, with attention focused on the non-immune population under one year of age up to pre-schoolers. Boosters every two years up to 20 years of age are suggested.

Encephalitis still poses a threat.

#### Other Health Programs

Rabies in animals remains a serious problem around the state. In 1964 a total of 290 cases were reported, compared to 320 in 1963 and 395 in 1962. Through July of 1965, 226 animal rabies cases were reported.

Food poisoning continues to be a problem. Last year 19 outbreaks were investigated involving over 700 persons.

Self-survey of local food service and vending programs is growing. This year over 40 departments are using the State Department's recommended procedures for self-analysis.

With respect to records, the State Department now has statistical data for all 600 water plants in the state stored on punch cards. Stream monitoring data also are stored on punch cards for quick review.

In addition to the long-standing eight-state cooperative anti-pollution program on the Ohio River, the Department was involved in three major interstate conferences on water pollution. Lake Erie conferences resulted in an agreement among five states and the federal government in regard to pollution of the lake.

#### Air Sampling Stations

With respect to air pollution, the Department is planning to move its 20 some air sampling network stations to new locations. In cooperation with the federal government the radiological fall-out program continues. Principal objective continues to be elimination of unnecessary exposure to radiation from x-rays used in the healing arts.

Still relatively undeveloped is the proposal that local health departments provide part-time health services to small industries.

Collection, storage and disposal of vast quantities of refuse, or solid wastes, continues to be a monumental problem. The Department has offered training courses in this field.

It has been an active year in training programs available to health officers. For example, 58 attended the four-day institute held in connection with the Ohio State Medical Association Annual Meeting in May; 22 newly appointed health officers made use of orientation sessions; nine attended short courses at Public Health Service training centers; and at least 43 others participated in conferences, seminars and workshops held by the State Department.



# Changes in Ohio Welfare ...

Legislation Passed by the Ohio General Assembly

Brings About Revisions Effective July 1, 1966

LEGISLATION sponsored by the Rhodes administration and passed by the Ohio General Assembly this year will bring about major changes in the administration of public welfare in Ohio. Following is a resumé of major changes reported to *The Journal* by Robert B. Canary, assistant director of the Ohio Department of Public Welfare.

On July 1, 1966, the employees in subdivision offices of aid for the aged will be transferred to county welfare departments and all city relief areas will be abolished. The county welfare department will thereafter be responsible for determining the eligibility of all persons who need public aid in Ohio except those who qualify for soldiers' relief. Standards of eligibility will be fixed by the state department of public welfare and all warrants for payment except to persons who receive general relief will be made from the state treasury.

A new system of financing takes into account the per capita tax duplicate in each county and the proportion of low income families. Financing will be uniform for all programs and should guarantee that services will be provided alike in each county.

House Bill 915 authorized the department of public welfare to set up a separate medical assistance program which would meet the financial needs for health care of all persons who receive public assistance and for other persons who would qualify for public assistance except for having enough money to meet their monthly minimum needs. This medical assistance program would conform to Title XIX of the recently amended Social Security Act. Under its provisions it will be necessary to provide the same kind of service to recipients of each program in every county. Fee schedules and limitations imposed on payment of health care would have to apply equally in such programs as aid for the aged and aid to dependent children. The combined program is expected to earn additional federal matching. Appropriations in anticipation of the additional money have been made to the department of public welfare so that it is expected that improvements will be possible in providing payment for health services, especially in the aid to dependent children program.

Legislation also will authorize the payment of aid for the aged to individuals in mental hospitals and

tuberculosis sanitariums. Payments for care in mental hospitals will be reimbursable from federal funds only to the extent that program improvements can be identified. This provision is expected to permit experimentation with new types of facilities for mental patients who do not require intensive psychiatric care but who do require supervision or group living arrangements.

Other significant welfare legislation included the extension indefinitely of aid to dependent children of unemployed parents. The use of this program in Ohio has been one of the factors in reducing the persons receiving poor relief from a 1963 figure of 140,000 to about 55,000 at the present time.

New legislation will also permit the continuation of aid to dependent children to children who are removed from their families by court order and placed in foster care.

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## AMA Schedules Conference On Air Pollution

Air pollution and chronic respiratory diseases will be attacked as interrelated problems during the American Medical Association's first Air Pollution Medical Research Conference to be held in Los Angeles at the Ambassador Hotel, March 2-4, 1966.

In addition to the AMA, six other medical and health organizations are mobilizing behind what may well be the largest concerted campaign to be conducted by the medical profession against these problems to date.

The national cooperating organizations include the American College of Chest Physicians, the American Thoracic Society and the United States Public Health Service.

Individuals interested in registration information should write: Air Pollution Medical Research Conference, Department of Environmental Health, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

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The Southwestern Ohio Society of Family Physicians, with assistance from the American Cancer Society, presented a seminar on "Current Concepts in the Treatment of Neoplastic Disease," on October 7. The program was held at the Carrousel Motel in Cincinnati.

# Ad Astra

**John H. Baird, M. D.**, Nokomis, Fla.; Johns Hopkins University School of Medicine, 1917; aged 75; died on or about September 18. A career Veterans Administration physician, Dr. Baird was formerly associated with at least one Ohio hospital. Survivors are his widow, his step-mother, a son, a sister and a brother.

**George Alexander Barton, M. D.**, Gallipolis; Cincinnati College of Medicine and Surgery, 1901; aged 87; died August 31; former member of the Ohio State Medical Association; member of the American Psychiatric Association. The third generation member of a family of physicians, Dr. Barton was a native of Gallia County and devoted a lifetime to practice there. Among affiliations he was a member of the Masonic Lodge and the Elks Lodge. Surviving are his widow, a son, a daughter and a sister.

**August H. Bruening, M. D.**, Parma; Western Reserve University School of Medicine, 1906; aged 88; died September 18; former member of the Ohio State Medical Association. A general practitioner of some 59 years standing, Dr. Bruening served virtually all of his medical career in Cleveland. He was a member of the Catholic Church, the Knights of Columbus and other Catholic orders. Survivors include his widow, a daughter and a son.

**Irwin F. Dice, M. D.**, Canton; Western Reserve University School of Medicine, 1913; aged 81; died September 28; member of the Ohio State Medical Association and the American Medical Association. A native of northeastern Ohio, Dr. Dice practiced

for 51 years in Canton. Among survivors are his widow, a daughter, a sister and two brothers.

**James A. Ellery, M. D.**, Shelby; Temple University School of Medicine, 1934; aged 59; died September 16 while on a vacation trip in the East; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Shelby since 1935, Dr. Ellery served as flight surgeon in the Air Force during World War II. He was a member of the Lutheran Church, the Masonic Lodge and the American Legion. Surviving are his widow, a son, a daughter, his mother, a brother and two sisters.

**Arthur William Friend, M. D.**, Akron; Queen's University Faculty of Medicine, 1929; aged 61; died September 29; member of the Ohio State Medical Association, a former delegate from Summit County to the OSMA and active on several OSMA committees; member of the International Anesthesia Research Society; diplomate of the American Board of Anesthesiology. Dr. Friend practiced for about 17 years in Akron where he was associated with Akron City Hospital. He was a member of the Episcopal Church. Survivors include his widow and two brothers — Dr. Amos E. Friend of Manchester, Conn., and Dr. Austin G. Friend, Seattle, Wash.

**J. Bliss Glenn, M. D.**, Greenfield; Miami Medical College, Cincinnati, 1909; aged 82; died September 25; member of the Ohio State Medical Association and the American Medical Association. A native of neighboring Fayette County, Dr. Glenn lived most

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\*Plotnick, M.: Int. Record of Med. 173:262, 1960.

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of his early life in the Hillsboro vicinity where his late father practiced medicine for many years. Dr. Bliss Glenn devoted nearly a half century to the practice of medicine in the Greenfield vicinity. His widow and a sister survive.

**Jack B. Horrocks, M. D.,** Cleveland Heights; Western Reserve University School of Medicine, 1943; aged 46; died August 30; former member of the Ohio State Medical Association. After serving in the Army Medical Corps during World War II, Dr. Horrocks took residency training in Cleveland before entering private practice. His specialty was neuropsychiatry. Surviving are his widow, a son, two daughters and his mother.

**Hans Lion, M. D.,** Cincinnati; Frederick-Wilhelms University Faculty of Medicine, 1921; aged 70; died September 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Lion practiced medicine in Germany before coming to this country in 1936. His practice was in the field of ENT and plastic surgery. Survivors include his widow, a son and a daughter.

**Alexander Stearns McCormick, M. D.,** Akron; University of Western Ontario Faculty of Medicine, 1910; aged 89; died September 9; member of the Ohio State Medical Association, the American Medical Association and the International Anesthesia Research Society. An individual of diversified talents, Dr. McCormick was physician, editor, historian, musician and soldier in addition to his activities in medical organization affairs. A native of Montreal, Canada, and college athlete, he served 18 years in the Canadian and British Armies, including combat service in the South African War. As a musician he is credited with composing 23 marches for Canadian and American bands. He was founder of the Doctors Orchestra in 1926 and was its director for many years. He was founder of the Summit County Medical *Bulletin* and was its editor from 1926 to 1940. He was secretary of the Medical Society for more than 25 years and its treasurer for many years. His articles in the field of history were numerous. He was one of the first physicians to specialize in anesthesiology and held several offices in anesthesiology societies.

**Anthony L. Pryatel, M. D.,** Lorain; St. Louis University School of Medicine, 1932; aged 58; died September 23; member of the Ohio State Medical Association, the American Medical Association and the American Society of Anesthesiologists. Dr. Pryatel was a native of Cleveland and was a general practitioner in the Lorain vicinity for some 29 years. He was a member of the Catholic Church and several Catholic orders; also a member of the Moose Club, Eagles Lodge and other organizations. Survivors include his widow, a daughter, two sons, a sister and four brothers.

**T. Laurance Saunders, M. D.,** Cincinnati; Columbia University College of Physicians and Surgeons,

1904; aged 86; died September 1. After a long practice in the New York area, Dr. Saunders in 1950 moved to Cincinnati where he was living in retirement. Surviving include his widow, six daughters, and two sons.

**Carl A. Schuck, M. D.,** Hamilton; St. Louis University School of Medicine, 1930; aged 58; died September 10 in a traffic accident; member of the Ohio State Medical Association, the American Medical Association, American Society of Internal Medicine; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A medical officer in the Air Force during World War II, Dr. Schuck retired with the rank of colonel. His practice in Hamilton extended to 1946. Surviving are his widow, a son and two daughters.

**Hazel P. Simms, M. D.,** Akron; Western Reserve University School of Medicine, 1924; aged 73; died September 27; member of the Ohio State Medical Association, the American Medical Association and the American Academy of General Practice. A former resident of Akron, Dr. Simms returned there to practice after completing her medical training. Among affiliations she was a member of the Zonta Club and the Christian Church. Surviving are her husband, Walter A. Renfand, and a brother.

**Leo H. Speno, M. D.,** Ithaca, N. Y.; Cornell University Medical College, 1930; aged 60; died September 7. A former practitioner in Cleveland, Dr. Speno moved out of the state in 1935. Survivors include his widow, two sons and three daughters.

**Joseph Stein, M. D.,** Cincinnati; University of Cincinnati College of Medicine, 1923; aged 66; died June 10; member of the Ohio State Medical Association and the American Medical Association. A native of neighboring Newport, Ky., Dr. Stein served most of his professional career in the Cincinnati area where his specialty was internal medicine. He served in the Medical Corps during World War II and held the rank of lieutenant colonel.

**John L. Stifel, M. D.,** Toledo; Johns Hopkins University School of Medicine, 1917; aged 73; died September 25; member of the Ohio State Medical Association, the American Medical Association, American Society of Internal Medicine and the Central Society for Clinical Research; diplomate of the American Board of Internal Medicine. A practicing physician for some 45 years in Toledo and active in organization work, Dr. Stifel was past president of the Academy of Medicine of Toledo. He also was a past president of the Northern Tri-State Postgraduate Association. A veteran of World War I, he was a member of the Rotary Club, Presbyterian Church and several other organizations. Survivors include his widow, two sons and a sister.

**Samuel Tamarkin, M. D.,** Youngstown; Ohio State University College of Medicine, 1925; aged 65; died September 18; member of the Ohio State Medical





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possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

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rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Association, the American Medical Association and the American Academy of General Practice. A general practitioner, Dr. Tamarkin served about 40 years in Youngstown as a physician. During World War II, he was in the Army Medical Corps and attained the rank of major. Among affiliations he was a member of the Temple and the Elks Lodge. Dr. Saul Tamarkin, also of Youngstown, is a brother. Other survivors include his widow, a son, a daughter, and two other brothers.

### Ohioan Named in Worldwide Study Of Psychiatric Terminology

Dr. Benjamin Pasamanick, professor of psychiatry in the Ohio State University College of Medicine, has been appointed to represent the United States for 10 years in a special project of the World Health Organization.

His appointment is to a group working on standardization of psychiatric diagnosis, classification and national statistics. The long-term WHO project is expected to create better understanding in areas where there has been disagreement in regard to diagnostic practices among different schools of psychiatry and in different countries. Objective is to find acceptable international classification of psychiatric disorders. Efforts will also be made to find means of improving collection, collation and analysis of international statistics.

Dr. Pasamanick is chairman of the subcommittee on mental disorder of the U. S. National Committee on Vital and Health Statistics. He was the American representative participating in the 1965 revision of the international classification of diseases.

Dale Philip Svendsen, second-year medical student in the Ohio State University College of Medicine, was awarded the first annual Chauncey D. Leake scroll and honorarium in pharmacology.

### Life Insurance Research Grants Are Awarded in Ohio

The Life Insurance Medical Research Fund announced a list of grants to institutions in aid of basic medical research. Among grants in Ohio are the following:

Cleveland Clinic Foundation, for research by Dr. Philip A. Khairallah on the mechanisms of action of vasoactive peptides, especially angiotensin, \$24,000.

University of Cincinnati, for research by Dr. Thomas E. Gaffney on the metabolism of catecholamines in septic shock, \$18,700.

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# Activities of County Medical Societies ...

## BUTLER

In late September, members of the Butler County Medical Society met with local units of the American Cancer Society for a meeting and program. The speaker was Dr. William Newton, director of pathology at Children's Hospital in Columbus, who discussed cancer in children from the pathologist's viewpoint.

## FRANKLIN

A physician who also is a member of the U.S. House of Representatives was guest speaker for the September 20 meeting of the Academy of Medicine of Columbus and Franklin County. He is Representative Durward G. Hall of Missouri, who is serving his third term in the U. S. Congress. The speaker discussed the role of the physician in regard to federal legislation, particularly in regard to the Social Security Amendments of 1965.

## HAMILTON

Dr. James Z. Appel, President of the American Medical Association from Lancaster, Pa., was speaker at the October meeting of the Academy of Medicine of Cincinnati. His topic was "Is There a New World for Medicine?"

The annual meeting of the Academy of Medicine of Cincinnati including installation of 1965-1966 officers was held on September 21 at the Academy auditorium. Dr. Robert M. Woolford was installed as president to succeed Dr. John J. Cranley.

Other new officers are Dr. Elmer R. Maurer, president-elect; Dr. Joseph Lindner, Jr., secretary; and Dr. Stanley D. Simon, treasurer. Executive secretary of the Academy is Mr. Edward F. Willenborg.

*The Cincinnati Journal of Medicine* devoted much

of its September issue to the comprehensive plan to solve the hospital needs of the Greater Cincinnati area. Included are photographs of each hospital or hospital group with historical sketches and other information.

## HARDIN

The Hardin County Medical Society met at San Antonio Hospital, Kenton, on September 14 for its regular monthly meeting.

Dr. Thomas Boles, pediatric surgeon associated with Ohio State University College of Medicine and Children's Hospital in Columbus, discussed the treatment of extensive burns and showed a movie on the subject.

The society discussed at some length and arranged for medical supervision of all the area football games. Dr. Walter Stoll, Jr., presented the comprehensive medical program presently being recommended by the Ohio State Medical Assn., which has been promoting the team physician concept for high school athletics to prevent injuries in high school sports.

Dr. Stoll was then appointed by the medical society to be the Kenton team physician so that a continuing program of preventive medicine in high school athletics could be instituted in this area.

## LORAIN

An attendance of 124 physicians, their wives, and 18 guests, marked the "kick-off" meeting of the Lorain County Medical Society for the fall season, when the group met to honor Lawrence C. Meredith, M. D., President-Elect of the State organization, with Mrs. Meredith; and William R. Schultz, M. D., the Eleventh District Councilor, with Mrs. Schultz.

The guests included Board members of the Lorain County Medical Foundation, and students who were



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to receive scholarships. The meeting, held at the Holiday Inn, was preceded by a social hour and dinner.

The meeting opened with introductions by President John W. Wherry, M. D., who gave a resume of the achievements of Dr. Meredith and Dr. Schultz and a standing ovation was accorded the two physicians.

Members new to the Society in the past twelve months, and their wives, were introduced, as were members of the Board of Supervisors of Lorain County Medical Foundation, and their wives. Established with surplus money from the polio immunization program in Lorain County, the Foundation provides scholarships to deserving students pursuing careers in various health fields. This year, grants totaling \$1500 were distributed, and Dr. Wherry called upon Mr. Owen F. Beckmeyer, Chairman of the Foundation's Screening Committee, to present the checks to those students who were able to be present.

A standing ovation was also given to Mrs. Ruth Zealley, who recently retired as Executive Secretary of the Society, when President John Wherry, M. D.,

called upon the Secretary-Treasurer, Dr. William Miller, to make the presentation of a gift from the membership to Mrs. Zealley.

Following a vote of thanks to all present who contributed to such a successful evening, business matters were conducted. Voted into Active membership were: Luis Alarcon, M. D., Lorain; Andrew Boysen, M. D., Elyria; Richard A. Moore, M. D., Elyria; Leslie G. Taylor, M. D., Lorain; and John M. Wright, M. D., Vermilion.

#### MAHONING

Dr. Herbert S. Kupperman, professor of endocrinology, New York University School of Medicine, was guest speaker at the September 21 meeting of the Mahoning County Medical Society. Dr. Kupperman was introduced by Dr. Joseph W. Tandatnick, program chairman. A social hour and dinner preceded the program.

\* \* \*

"Expanding Problems Affecting Rural Health" was the subject for discussion when members of the Rural Health Committee of the Mahoning County

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Medical Society appeared on the "Diagnosis" broadcast carried over Station WFMJ, Youngstown, on September 21. Physicians participating included Drs. Kenneth Camp, James Finley and Clyde Walter.

#### SUMMIT

Dr. Thomas R. Kelly, was principal speaker for the September 6 meeting of the Summit County Medical Society in Akron. His topic was "Neurovascular Etiology of Experimental Pancreatitis."

#### Psychiatric Film Available

"Psychiatric Services in General Hospitals" is the name of a 25-minute sound film in color presented by the American Hospital Association, the American Psychiatric Association and E. R. Squibb and Sons, in cooperation with the Hospital Research and Educational Trust. The film may be purchased for a nominal price or shown on a rental basis, by applying to the American Hospital Association Film Library, 840 N. Lake Shore Drive, Chicago, Illinois 60611.

#### Ohio Women Physicians Participate In National Group Meeting

Three Ohio women physicians are scheduled to play leading roles when the American Medical Women's Association holds its 50th anniversary scientific program in Chicago, Saturday, November 13. "A Symposium on Medicine in the Next 50 Years," is the program basis for the meeting in the Sheraton-Chicago Hotel. Registration opens at 9:00 a.m. with the program starting at 10:00 o'clock.

Dr. Margaret J. Schneider, as president-elect of the organization, will preside for both morning and afternoon sessions.

Dr. Evelyn V. Hess, associate professor of medicine at the University of Cincinnati College of Medicine, will speak on "The Future of Immunology."

Dr. Mary Martin, chief of the Department of Plastic Surgery at Good Samaritan Hospital, Cincinnati, will moderate a panel discussion on topics covered during the morning session.

## WITH FAILURES

In a 7½-year study of 115 patients treated with oral sulfonylurea drugs, Beaser<sup>1</sup> found that nearly one-half (54) were failures—either primary or secondary. Addition of DBI to the sulfonylurea reversed oral treatment failures in 42 cases. This combined therapy "practically doubled the longevity of treatment possible with oral drugs." Other investigators also report on combined therapy:

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"DBI is 'often useful in augmenting an incomplete response to one of the sulfonylurea drugs.'"<sup>3</sup>

"...patients who are sulfonylurea failures may respond effectively to the combined therapy [with DBI]."<sup>4</sup>

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show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in nondiabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **Contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **Pregnancy Warning:** During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided. Consult product brochure.

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1. Beaser, S. B.: J.A.M.A. 187:887, 1964. 2. Marble, A.: Appl. Therap. 5:614, 1963. 3. Moss, J. M. et al.: Med. Times 92:645, 1964. 4. Linder, M. et al.: New York St. J. Med. 62:337, 1962.

# Woman's Auxiliary Highlights...

By MRS. S. L. MELTZER, Publicity Committee

Chairman, 2442 Dorman Dr., Portsmouth

ITS COVER PAGE is inviting and colorful. Its inside pages are informative and helpful. What is IT? The new loose-leaf Auxiliary Workbook, recently off the press, published for State Board members, county presidents and presidents-elect (and, in effect, for all county chairmen to consult). Compiled by Mrs. Herbert Van Epps, state president, and Mrs. John D. Dickie, immediate past state president, this Workbook is a remarkably comprehensive and effective presentation of data which will be of invaluable use to the various officers in the performance of their duties during the year.

Important information is under one cover — virtually at the finger tips when needed. Later, as certain pages inevitably become outdated, new sheets will replace the ones to be discarded (this book is to be passed on eventually to the succeeding officer). It is, in a sense, the new auxiliary bible. It was no small task to put such a book together. Mrs. Van Epps and Mrs. Dickie deserve a resounding "thank you" not only for the time and effort they expended in this direction, but even more important for their realization that such a Workbook was badly needed. Marge Dickie has remarked that it is "far from perfect." Maybe so. But one thing we do know: it comes more than reasonably close!

## Members-At-Large

There are many doctors' wives in Ohio who would like to become Auxiliary members who have not because, unfortunately, their particular county is not organized. For such women, there is an alternative. They can become members-at-large and they are very much wanted by the State Auxiliary. Do YOU know any such women? Or are you perchance one of them? If so, please contact Mrs. John B. Hazard, Box 171, County Line Road, Gates Mills 44040. Mrs. Hazard will welcome you with open arms and be delighted to explain how you can become, on your very own, an integral part of the doctors' wives' group. (An aside to the doctors in unorganized counties who *might* just be casting a quick eye over this column: Urge your wives to become members-at-large. There's a place for them — and a need for them.)

## Why the Slow-Down?

It hardly seems necessary to point up the importance of AMA-ERF in this column. No county auxiliary could possibly be unaware of AMA-ERF,

what it stands for, what its vital job is. Then why are so many local groups slower this year in getting their contributions in to the state chairman? At the relatively recent fall Board meeting, Mrs. R. K. Ramsayer unhappily announced that this year's figures were behind those of last year for the comparable period. What's the answer? We don't know exactly, of course. We cannot conceive that any local auxiliary would be letting down on one of the most vital of our projects. Whatever the reason, PLEASE GET BUSY — please outdistance last year's record this year. In the light of what is happening Federal-wise where medicine is concerned, the already outstanding performance of AMA-ERF must be magnified even more — and there we CAN be of considerable help. Get moving! And get those checks in to the state AMA-ERF treasurer — Mrs. F. P.

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### Around the State

Guernsey auxiliary got off to a good start with a meeting at the home of Mrs. J. T. Goggin at Cedar Hills. A contribution was voted for United Fund and the group also voted to continue its support of a local student nurse in training at Riverside Hospital in Columbus. Assistant hostesses for the meeting were Mrs. J. W. Camp, Mrs. Jesse B. Kellum, Mrs. Dayle O. Snyder and Mrs. John P. Haun.

Speaking of AMA-ERF, the Hamilton County group started to launch its sale of Christmas cards and personalized stationery back in August! Forty-one doctors' wives, all members of the committee headed by Mrs. Paul E. Foldes, are striving to exceed the \$2500 profit earned by last year's sale. Area chairmen have been holding informal coffees in their homes, where auxiliary members, their friends and neighbors have been choosing from among 300 greeting cards in every price range. There have been 40 such coffee hours in all . . . Those preferring to order by mail have received packets containing a selection of four different cards. Industries have been contacted by Mrs. Foldes and Mrs. Don N. Berning for business orders. Assisting Mrs. Foldes in the overall plan for sales are Mrs. John J. Phair and Mrs. Joseph E. Ghory.

Mrs. John Toepfer, president of the Hamilton group, named Mrs. W. P. Mazur in charge of the prenatal and well-baby clinic projects where the volunteers hope to include health instruction for clinic patients. Another chairman is Mrs. George D. Griffin in charge of a recruiting and placement service for retired people. International health and hospitality are combined in Mrs. Edward Woliver's committee. Mrs. Manuel Rodarte's committee is in charge of 36 health career clubs in local high schools. Mrs. Donald R. Thomas directs the nursing scholarship program. Three such scholarships have been awarded this year to student nurses at the University of Cincinnati School of Nursing.

Knox County auxiliary held its late September meeting at the home of Mrs. Thomas Bogardus. The business session was conducted by Mrs. William Perle, president. Mrs. Robert Sooy reported that five barrels of medical supplies collected from doctors' offices were shipped to the Far East. The members voted for a Christmas card project for AMA-ERF. Appointed to the budget committee were Mrs. Robert Hoecker, Mrs. A. S. Mack and Mrs. James McCann. A book review and Tea was held at the Mt. Vernon Country Club in October to which the public was invited. Mrs. Sarah Schwartz, a Columbus attorney, reviewed three books written by Jean Kerr.

### More from Here and There

An interesting and unusually varied program of study groups has been offered members of Lucas County by Mrs. Joseph Roshe, chairman. The "cur-

riculum" includes: three levels of French, beginning Spanish, gardening, three bridge groups, finance, great decisions (foreign policy), ballet, tennis and social dancing. (Virtually something for everybody!)

Mrs. Irvin McConnell has been busy recruiting volunteers for the x-ray buses, Citizens' Day Care, the Family Life Education program and the Mental Hygiene Clinic. Three opportunities to serve the latter group are offered—as clerical assistants; as group workers with children whose mothers are in therapy; as qualified teachers of emotionally disturbed children.

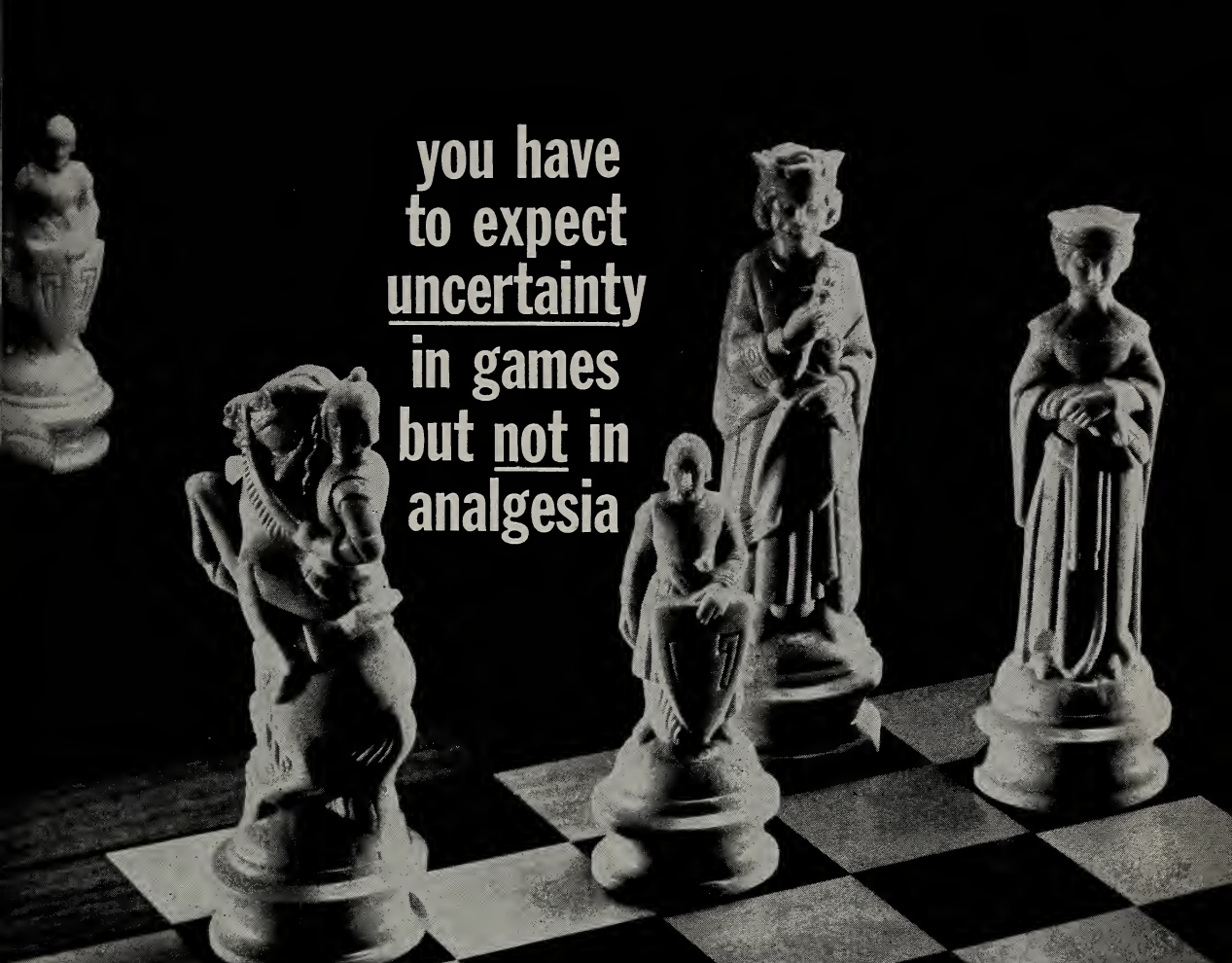
Scioto County had its "Books and Authors" luncheon again—a fund-raising project that proved very successful last year. This year it featured Barbara Robinson of Dover, Massachusetts, nationally known writer of short stories and children's books, and Raymond Embree, district librarian. Some two hundred members and guests gathered at the Elks City Club for this cultural and benefit undertaking, made possible through the cooperation of Marting's Book Store. It is hoped this may become an annual event. Mrs. Robinson described the problems faced by an author. She discussed ideas and backgrounds and seemingly trivial things that can help to spark a plot. Mr. Embree, for many years librarian at the Federal Reformatory in Chillicothe, discussed book censorship. Mrs. Miller F. Toombs was chairman of the "Books and Authors" luncheon, assisted by Mrs. Spencer W. Miller, Mrs. J. P. McAfee, Mrs. Jerome M. Rini, Mrs. Louis Chaboudy, Mrs. George Blume, Mrs. Joseph Gohmann and Mrs. Robert Counts.

### Provocative?

The scene: a recent dinner for doctors' wives. The speaker: a charming, articulate psychiatrist. The subject: "Maintaining Emotional Balance in the Doctor's Family." The quotes (just a few): "There are hazards to being a doctor's wife . . . By and large, doctors are wedded to their jobs and that plays the devil with home life and personal relationships . . . doctors are perfectionists . . . it isn't the doctor's fault but he's subject to undue adulation, forced on him by the culture of the day . . . His best hours are with his patients; his family gets the dregs . . . he has more responsibility than he can comfortably handle . . . give this man solace, comfort; minister to his dependence because he has to be so very independent as an M. D. . . . families of doctors have to be a unit to serve people . . . give yourselves the Congressional Medal of Honor; without your endeavors, doctors wouldn't be fit to do their jobs . . . without you, his wife, the doctor wouldn't have a Chinaman's chance . . ." Well, girls??

Dr. Milo B. Rice recently gave up his practice of 25 years standing in Pandora to become Putnam County health officer.





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## Selective Service Issues Call Involving 1529 Physicians

In late September the National Headquarters of the Selective Service System released Operations Bulletin No. 280, stating that it had received a special call for 1529 physicians, 350 dentists, and 100 veterinarians to enter on active duty for the first quarter beginning in January 1966.

Under the heading "physicians not in internship," the bulletin announced that in order to fill the call for physicians it is requested that local boards immediately:

Order for physical examination all physicians in Classes I-A, I-A-O, II-A, II-S, and III-A, unless they have been examined since April 1, 1965.

Obtain current classification information from all physicians in the foregoing classes. "Within the time limit set by local boards for receipt of this information, local boards shall reopen and consider anew the classification of these physicians. This processing including adjudication of appeals should be completed by December 1, 1965."

"In determining the classification of these physicians the current personnel requirements of the armed forces shall be considered. Physicians should not be classified in Class II-A to complete residency unless the local boards determine their services are absolutely essential to the operation of the hospital."

A communication from James C. Cain, M.D., Chairman of the National Advisory Committee to the Selective Service System, states that it appears from the age group involved that many of the individuals who will be called for examination will be in the midst of residencies. Dr. Cain further advised deans of medical schools and other schools involved that if a disproportionate number of residents are called from one hospital or one department or service in a hospital, appeal should be made by calling the matter to the attention of the state chairman and the National Advisory Committee so that appropriate advice may be given to the Selective Service System.

## Workmen's Compensation To Pay Physician's Usual Fee

The Ohio Industrial Commission's Bureau of Workmen's Compensation in the future will pay the physician's usual and customary fee in workmen's compensation cases. Dr. Raymond B. Hudson, chief medical officer, announced. The policy began early in October.

The Industrial Commission fee schedule has been discarded in favor of the new policy. The action came on recommendation of the OSMA Council following similar recommendation of the OSMA Committee on Workmen's Compensation and a poll of County Medical Societies.

A new handbook explaining rules and procedures under the new system of payment is in preparation, and will be mailed to physicians as soon as available.

## Organization Is Placing Doctors In Needy Areas of Free World

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**BROWN**—John A. Powell, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown. 3rd Sunday, monthly.

**BUTLER**—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton. 4th Wednesday.

**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.

**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p. m., monthly, Clinton Memorial Hospital.

**HAMILTON**—Robert M. Woolford, President, 47 E. Hollister St., Cincinnati 45219; Mr. Edward P. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

**WARREN**—O. Willard Hoffman, President, 20 E. Fourth St., Franklin; Ray E. Simendinger, 901 Broadway St., Lebanon.

### Second District

Councilor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

**CHAMPAIGN**—Isador Miller, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.

**DARKE**—Edward H. Kirsh, President, 261 East Main Street, Gettysburg; Delbert Bickensstaff, Secretary, South West St., Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Roger St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

**SHELBY**—George J. Schroer, President, 322 Second Ave., Sidney; Alfonso Kisielous, Secretary, Ohio Bldg., Sidney.

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Council: Frederick T. Merchant, Marion 43305  
1051 Harding Memorial Pky.

**ALLEN**—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima. 3rd Tuesday, monthly, except June, July and August.

**AUGLAIZE**—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville. Called meetings.

**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.

**HANCOCK**—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.

**HARDIN**—Glen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center. 2nd Tuesday, monthly, except June, July and August.

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**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.

**SENECA**—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.

**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.

**WYANDOT**—Franklin M. Smith, President, E. Saffle Ave., Box 68, Sycamore; Robert E. Goynne, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

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Councilor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

**DEFIANCE**—John W. Cullen, President, Box 218, Defiance; William S. Busted, Secretary, Box 218, Defiance. 1st Saturday, monthly.

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**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon. 1st Tuesday, monthly.

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**OTTAWA**—Robert Reeves, Route 1, Oak Harbor; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



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**SANDUSKY**—J. L. Zimmerman, President, Memorial Hospital, Fremont; Mrs. Patsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.

**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

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10525 Carnegie Ave.

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**CUYAHOGA**—William F. Boukalik, President, 20030 Scottsdale Blvd., Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 6.

**GEAUGA**—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanour Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

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Councilor: Edwin R. Westbrook, Warren 44481  
438 North Park Ave.

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**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.

**PORTAGA**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARK**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., N.W., Canton 44702. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

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Councilor: Benj. C. Diefenbach, Martins Ferry 43935  
30 S. 4th St.

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**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

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**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Boocks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

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**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

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**SCIOTO**—William E. Daeher, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Sciotoville. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

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**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 23 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

**ROSS**—Paul F. MacCarter, President, 60 Central Center, Chillicothe; Richard L. Counts, Secretary, 56 E. Second St., Chillicothe.

**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

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1749 Cleveland Road

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**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P. O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

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**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

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**RICHLAND**—Stanley L. Brody, President, 327 Park Ave W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.

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## Welfare Agencies Agree to Unsigned Statement on Non-Discrimination

THE Department of Health, Education and Welfare has approved a substitute statement which physicians may use in lieu of the non-discrimination pledge originally required by the Ohio Department of Public Welfare in its health care programs, an official of the Department announced.

The approved statement reads as follows:

"These services were provided in full compliance with Title 6 of the Civil Rights Act of 1964 to the end that no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity administered or supervised by the Ohio Department of Public Welfare."

Any physician submitting a bill to the Ohio Department of Public Welfare may have this statement typed or stamped on the bill. It does not require his signature. It has been suggested that physicians who treat a significant number of welfare patients have a stamp made to facilitate inclusion of the statement with the bill.

The Ohio Department of Public Welfare has said that it will continue to use the non-discrimination pledge for physicians who signed and returned the pledge to the Department. Physicians who have not signed the pledge or who have rescinded it need only to have the above statement stamped or typed on the bill.

Physicians who wish to rescind their non-discrimination pledge may do so by informing the Ohio Department of Public Welfare in writing that they "hereby rescind the non-discrimination pledge."

The Ohio Department of Public Welfare mailed the non-discrimination agreement cards in mid-summer to all physicians on its records and to other persons who perform services for the Department, with instructions to sign the card and return it.

### Programs Involved

The following programs, administered or supervised by the Ohio Department of Public Welfare are involved: Aid for the Aged, Aid for the Blind, Aid to the Permanently and Totally Disabled; Aid to Dependent Children; Child Welfare Services; Services to Crippled Children; Distribution of Surplus Commodities; Distribution of Food Stamps; Vocational Rehabilitation and other services to the blind. Many of these services will be greatly expanded, and other services added under provisions of the

Social Security Amendments of 1965, and other federal legislation.

When the cards were first sent out, the Ohio State Medical Association protested to the Department of Public Welfare, which readily agreed to seek a solution to the problem. The OSMA's position was that the Principles of Medical Ethics more than cover any question of discrimination, and that a demand on physicians to sign an agreement that they would abide by the law was in itself an act of discrimination. It was pointed out that the Civil Rights Act itself does not require such an agreement; the demand was from the federal Department of Health, Education and Welfare.

The Association further recommended to physician members that they defer signing such an agreement until they had studied the Civil Rights Act and all regulations pursuant to it, and until they had received legal advice as to the agreement's possible effects on their practices.

Officials of the Ohio Department of Public Welfare have cooperated closely with the Association and made numerous recommendations to the Washington offices of HEW before the agreement was reached.

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### COMING MEETINGS

#### Ohio State Medical Association:

- 1966 Annual Meeting, Cleveland, May 24 - 28.
- 1967 Annual Meeting, Columbus, Week of May 14.
- 1968 Annual Meeting, Cincinnati, Week of May 12.

#### American Medical Association:

- 1965 Clinical Convention, Philadelphia, Nov. 28-Dec. 1.
- 1966 Annual Convention, Chicago, June 26-30.

American Academy of Cerebral Palsy, Sheraton-Cleveland Hotel, Cleveland, December 1-4.

Interstate Postgraduate Medical Association of North America, Sheraton-Cleveland Hotel, Cleveland, November 15-18.

U. S. Public Health Service Symposium on Transmission of Viruses by the Water Route, Cincinnati, December 6-8.

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Dr. Morton A. Stenchever heads a \$45,275 research project at Western Reserve University for the study of cytogenetics of human reproductive failure.

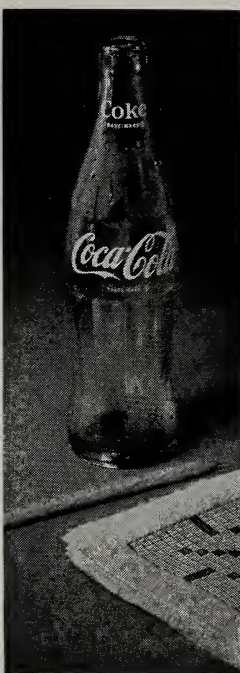




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# Yellow Fever in Ohio

N. PAUL HUDSON, Ph.D., M.D.\*

## PART I

THE fact that yellow fever has occurred in Ohio is generally recognized by medical historians. Its occurrence is not more widely known, however, because the public of today cannot appreciate the conditions that brought the disease to Ohio's shores in the last century. It reasonably considers the malady as belonging to the tropics and remote from the experience of this northern state. Such has not always been the case, and the study to be reported here was designed not only to learn where, when, and how much yellow fever existed in this state, but more particularly to determine the circumstances that allowed it to happen.

### I. A Severe Epidemic Disease In Gallipolis in 1796

The first incident to be analyzed was the outbreak of an acute febrile disease in Gallipolis in the late summer of 1796. The civilian populace is variously estimated to have consisted of from 100 to 150 persons, remnants of the 500 French immigrants who established the community in 1790. At the same site was a U.S. Army garrison, presumably numbering 25 to 50 men.

Two first-hand accounts have come down to us. A traveler, Mr. Andrew Ellicott,<sup>1</sup> recorded that "Many of the inhabitants, this season, fell victims to yellow fever. The mortal cases were generally attended with the black vomit." Major Prior<sup>2</sup> of the garrison reported to the Surgeon General of the Army that the symptoms of the malady suffered by his troops were "a chill, followed by headache, pains in the back and limbs, red eyes, constant sickness at stomach, or vomiting, and generally, just before death, with a vomiting of matter like coffee-grounds. They were often yellow before, but almost always after death." Death occurred generally from the seventh to eleventh day and sometimes on the fifth or third. Half the soldiers were said to have died in 10 days. Other writers have variously stated "a third of the French population," "many inhabitants," "17 persons," and so on, had fatal attacks of illness.

Although local medical records have not been found, there is no doubt but that a severe epidemic

took place. Writings of laymen for 50 years from that time refer repeatedly to the acuteness of the outbreak, its high incidence and mortality rate, presumed causes, and cessation with frost. The term *yellow fever* is frequently used, but sometimes *ague*, or *bilious*, *malignant* or *intermittent fever*.

Our first concern is to attempt a judgment as to whether the severe epidemic was in fact yellow fever. The famous Ohio physician and author, Daniel Drake,<sup>3</sup> reviewed the evidence in his classic book of 1850. He came to the conclusion that the malady was not yellow fever but probably was autumnal remittent fever (malaria). He based his opinion on his several observations that there was much confusion in terminology at the time between yellow fever and various forms of fever or *ague*; the elevation of Gallipolis above sea level (500 feet) was more than the currently accepted limit for yellow fever (400 feet); the isolated epidemic occurred in an "infant village" of rural rather than urban character; and the symptoms described by Ellicott were not definitive of yellow fever.

Further medical evaluation of the Gallipolis epidemic of 1796 was not recorded until the widespread occurrence of yellow fever in the Mississippi and Ohio River valleys in the 1870's (see II, below). Then Minor,<sup>4</sup> who as Health Officer of Cincinnati saw numerous cases of the disease, revived without critical analysis the yellow fever diagnosis of the early Gallipolis outbreak. Keating,<sup>2</sup> in his account of the devastating epidemic in Memphis in 1878, seemed likewise to accept the Gallipolis episode as yellow fever.

In our analysis of the situation we are privileged to take into account knowledge not available to the critics of the last century: necessity of introduction of the causal agent into an isolated northern community and the transmission by the *Aedes* mosquito. Although the clinical descriptions given by Ellicott and Major Prior are most tempting as indicating yellow fever, we now recognize that definitive circumstances are stronger arguments than the symptoms reported. We accept as crucial the further statements of Ellicott that his was the first boat that descended the river in the Spring and sufficient time had not elapsed for a (sail) boat to have ascended the rivers from New Orleans where the disease existed that year. Although Ellicott after assuming the malady was yellow fever argued only for its hav-

\*Dr. Hudson, Columbus, is Professor Emeritus of Microbiology, The Ohio State University College of Medicine; 1963-1964 President of Ohio Academy of Medical History; former service (1927-1930) with Rockefeller Foundation, yellow fever research, West Africa and Rockefeller Institute.

Read at the annual meeting of the Ohio Academy of Medical History, held in Columbus, Ohio, on May 9, 1965.



ing arisen spontaneously in Gallipolis because of the circumstances he described, we can affirm that the same isolation means it could not have been that disease. Thus Drake and our modern thought come to the same opinion but for different reasons.

An alternative diagnosis is not easy. The chances are that Drake was right in assessing the epidemic to be what is now called malaria; this in its various forms was a common malady in the Midwest under circumstances like those at Gallipolis. If this was the case, the particular outbreak with its extreme symptoms and high mortality would have been exceptionally severe. Further conjecture on diagnosis is not warranted.

## II. Yellow Fever in the 1870's

We can turn from the earlier uncertainty of the Gallipolis episode to the more reliable recognition of yellow fever along the Ohio River in 1871, 1873 and 1878. The occurrence in these years reflected the periodic epidemics of the gulf states and of communities on the Mississippi River.

Health records were not routinely kept in the Midwest in the last century, and so we must rely on special accounts of epidemics and reviews of disease. Drake's<sup>3</sup> book of 1850 records no yellow fever on the Ohio River to that date. The first case reliably reported (Minor<sup>4</sup>) as having occurred in Ohio was that of a man who came from Natchez, Miss., and who died in Cincinnati in 1871. The next three cases, also in Cincinnati, were in 1873, the first patient a steamboat captain who contracted the fever

in Memphis and the other two "imported cases" in the pest house; all were fatal attacks.

These few instances set the pattern for the outbreak in 1878. Yellow fever suffered in Ohio that year was an extension of the severe epidemic along the Mississippi that came to a peak in Memphis where over 5000 died out of a population of 20,000 persons. The disease was imported into Ohio by travelers fleeing the epidemic, by passengers on steamers and trains, by steamboats and their barges themselves as they moved up the river, and from unidentified sources.

Thirty-five cases developed in Cincinnati that year, among which there were 17 deaths. Illness occurred in spite of a quarantine against importation of the disease from river and hinterland, which was in effect from the diagnosis of the first case (July 28) until frost (October 17). Among the first patients were two dock laborers whose presumed exposure amounted to handling a bale of rags and opening a piece of baggage.

(To Be Continued in January Issue)

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1. Ellicott, A.: Yellow Fever in the Western Country. *Medical Repository*, 4:74, 1801.
2. Keating, J. M.: *A History of the Yellow Fever. The Yellow Fever Epidemic of 1878, in Memphis, Tenn.* Memphis: The Howard Association, 154 pp., 1879.
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4. Minor, T. C.: *Report on Yellow Fever in Ohio, as It Appeared During the Summer of 1878.* Cincinnati: Cincinnati Lancet Press Print, 122 pp., 1878.

**ANNIVERSARY GREETING TO A FIRM FRIEND.**—Wherever the going is tough there you will find working quietly and without fanfare the Salvation Army. This organization, dedicated to "helping people at the point of need, whatever the need may be," is celebrating its 100th anniversary this year. Founded on July 2, 1865, in the East London slums by William Booth, its service quickly spread throughout the world. It came to this country officially in 1880. Working from the very start side by side with the medical profession, its view of the rehabilitation of the whole man led it into the way of health services for those it served.

Today throughout the world the Salvation Army operates 31 general hospitals, 38 maternity hospitals, 10 institutes for the blind, 70 dispensaries and clinics, 60 foundling hospitals and nursery centers, 6 leprosaria, 30 centers for alcoholism, and 88 maternity homes for unwed mothers. This is a sizable medical enterprise and one of great consequence to world health. This, in addition to the many other social services provided by this organization, makes of it the great force for good that it is.

The Army does one thing in England that we wish could be extended to this country, and that is the establishment of Eventide Homes, hostels for the elderly. We are in very great need of this sort of facility and the Army would do it superlatively. For all its help the medical profession is truly grateful, but, like *Oliver Twist*, has its hand out for more. —EDITORIAL: © *New York State Journal of Medicine*, November 1, 1965.



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## 78 of 88 County Medical Societies Represented in Attendance at OSMA District Conferences

Seventy-four of Ohio's 88 county medical societies were represented at the OSMA 1965 Councilor District Fall Conferences held September 22 through October 14.

Total registration for the conferences, held for county society officers and key committee chairmen, was 348, with the Tenth and Eleventh Districts tied for the highest number of registrants—38 each. Three districts—Second, Fifth and Sixth, each had a registration of 37.

Also represented at the conferences by board members was the OSMA Woman's Auxiliary. In addition, field men from the American Medical Association American Medical Political Action Committee attended most of the meetings.

Program content for the conferences included Medicare, American Hospital Association, regional hospital planning, Report of the President's Commission on Heart Disease, Cancer and Stroke, the poverty and Appalachia programs, a review of 1965 state and Federal legislation, the 1966 OSMA Annual Meeting, and Council-recommended county medical society billing for voluntary membership in AMPAC and the Ohio Medical Political Action Committee.

In addition, each county medical society represented was asked to report on its projects and activities.

District Councilors presided at the meetings. Speakers included President Henry A. Crawford, President-Elect Lawrence C. Meredith, Executive Secretary Hart F. Page and Administrative Assistants Herbert E. Gillen and W. Michael Traphagan. The conferences were arranged and conducted by Charles W. Edgar, OSMA Director of Public Relations.

### Pharmaceutical Industry's Story Told to Ohio Audiences

In Ohio alone, Smith Kline & French Laboratories' speakers have given some 569 talks before audiences totaling more than 22,700 persons. Nationwide more than 10,000 talks have been given by the company's speakers in its campaign to tell the story of the pharmaceutical industry to the American people.

A speaker for the company declared that the successful program is creating better understanding not only for the pharmaceutical industry, but also for other members of the health team including medicine.

Persons interested in having a speaker for a group meeting may write Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pa. 19101.

Dr. Joseph M. Foley, Cleveland, has been named to the Advisory Board of Ursuline College.



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Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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## 14 New Medical Schools Planned For Nation in Near Future

Ohio's new medical school at Toledo, the Toledo State College of Medicine, is one of 14 in the United States expected to be in operation by 1970, according to the annual report of the American Medical Association's Council on Education, published in the November 15 *JAMA*.

This number will bring to 101 the nation's total of schools of medicine, and mark an "era of major expansion" in American medical education, the report notes. "Of obvious and immediate importance is the fact that 800 to 1,000 new positions will be available to qualified medical applicants. This will help to meet the urgent national need for more physicians."

In addition to these 14 firm commitments to build schools, at least 10 other institutions "seem to be reasonably good possibilities" to follow through with the development of new schools.

Over the past 20 years, the number of medical schools has increased steadily from 77 schools in 1945 to 88 in 1965. The next five years, however, will mark the period of greatest expansion.

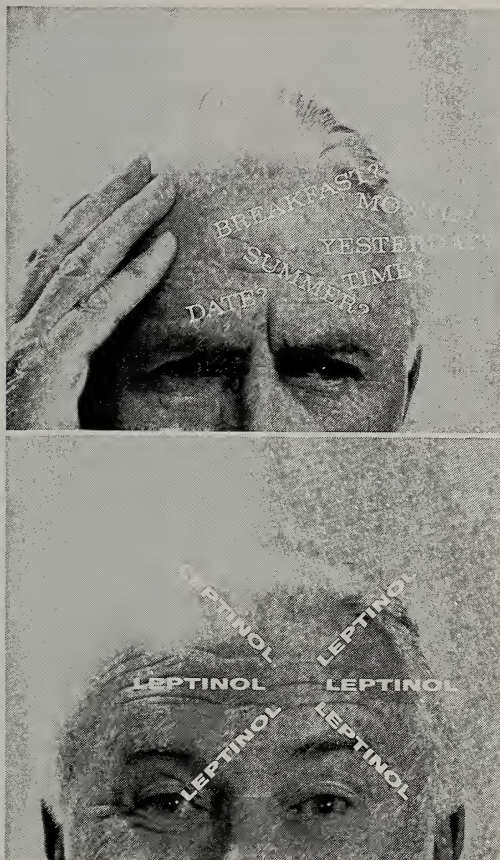
Eight of the 14 schools being planned will provide full four-year programs leading to the M.D. degree. The other six are envisioned as two-year schools of the basic medical sciences.

"However, three or four of the latter may well progress directly to four-year programs after they have become firmly established," The Journal said.

The four-year schools: The University of Arizona College of Medicine, Tucson; University of California, San Diego, School of Medicine; University of Connecticut School of Medicine, Farmington; Milton S. Hershey Center, Pennsylvania State University, Hershey; Mt. Sinai School of Medicine, New York City; South Texas Medical School, University of Texas, San Antonio; University of Massachusetts, and Toledo State College of Medicine, Toledo, O.

The two-year schools: Brown University Program in Medical Science, Providence, R. I.; University of Hawaii Medical School, Honolulu; Michigan State University College of Human Medicine, East Lansing; Rutgers University Medical School, New Brunswick, N. J.; University of California at Davis, and the University of New Mexico School of Medicine, Albuquerque.

The Cuyahoga County Unit of the American Cancer Society has as guest speaker for its October annual meeting Dr. Emerson Day, president of the Strang Cancer Prevention Clinic of New York City. He urged physicians to use more thorough tests in their examination of patients to detect cancer in its early stages. Other speakers were Dr. James W. Reagan and Dr. Austin S. Weisberger, both of Cleveland.



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Side Effects:—overdosage may produce tremor, convulsions or respiratory paralysis.

Caution should be taken when treating patients with a low convulsive threshold.

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Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

### Contraindications

Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

### Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination,

including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

### Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

### Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use,

reversible thyroid hyperplasia may occur infrequently.

### Average Dosage

Initially, give 400 mg. daily (one capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

**Note:** The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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No untoward side effects have been reported in 12 years of clinical use.

*Literature on indications and dosage available on request.*

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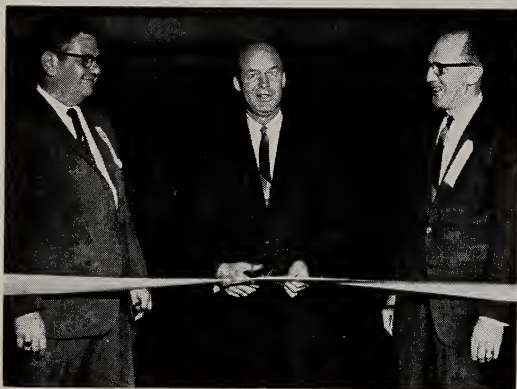


BALTIMORE, MARYLAND 21201

## Mayor Joins Toledo Academy in Dedication of Addition

Toledo Mayor John Potter was guest of honor and cut the ribbon to open the new addition to the Toledo Academy of Medicine on October 2. Hundreds of doctors, their wives and guests participated in the ceremonies and viewed the new improvements.

From the parking lot, a viewer goes through a small garden with illuminated fountain into a large multi-purpose room. Furnished as a lounge, it converts easily into a dining room or meeting room.



Mayor John Potter of Toledo is shown cutting the ribbon to officially open the new addition to the Toledo Academy building. With him are Academy President R. P. Whitehead, on the left, and Academy Trustee William A. Blank.

Adjacent are kitchen, equipment, storage and rest rooms. Across the hall are three new executive offices, the board room and committee rooms.

The new addition adds 4532 square feet of new space to the building now 15,216 square feet in size. Officers of the Academy say the building now provides a comfortable, adequate and pleasant environment for business, educational and social purposes.

The addition represents an investment of \$173,000. The Library Association added a second floor providing over 900 square feet of new stack space, thus meeting the needs for another ten years, officers affirm.

Dr. Charles E. Mengel, recently of the Duke University Medical Center, has been appointed to The Charles Austin Doan Chair of Medicine at Ohio State University College of Medicine, where he is serving as associate professor of medicine and director of the clinical service of hematology. The chair is named for Dr. Doan, Emeritus Dean of the College of Medicine.

The film "Recognition and Management of Anxiety," is developed for showing to physicians in psychiatric or non-psychiatric practice; 38 minutes, black and white with sound. The sponsor's product plays a part in the film. On loan from Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

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**Indications:** 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

**Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

**Precautions:** *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

*Benactyzine hydrochloride*—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

*Meprobamate*—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

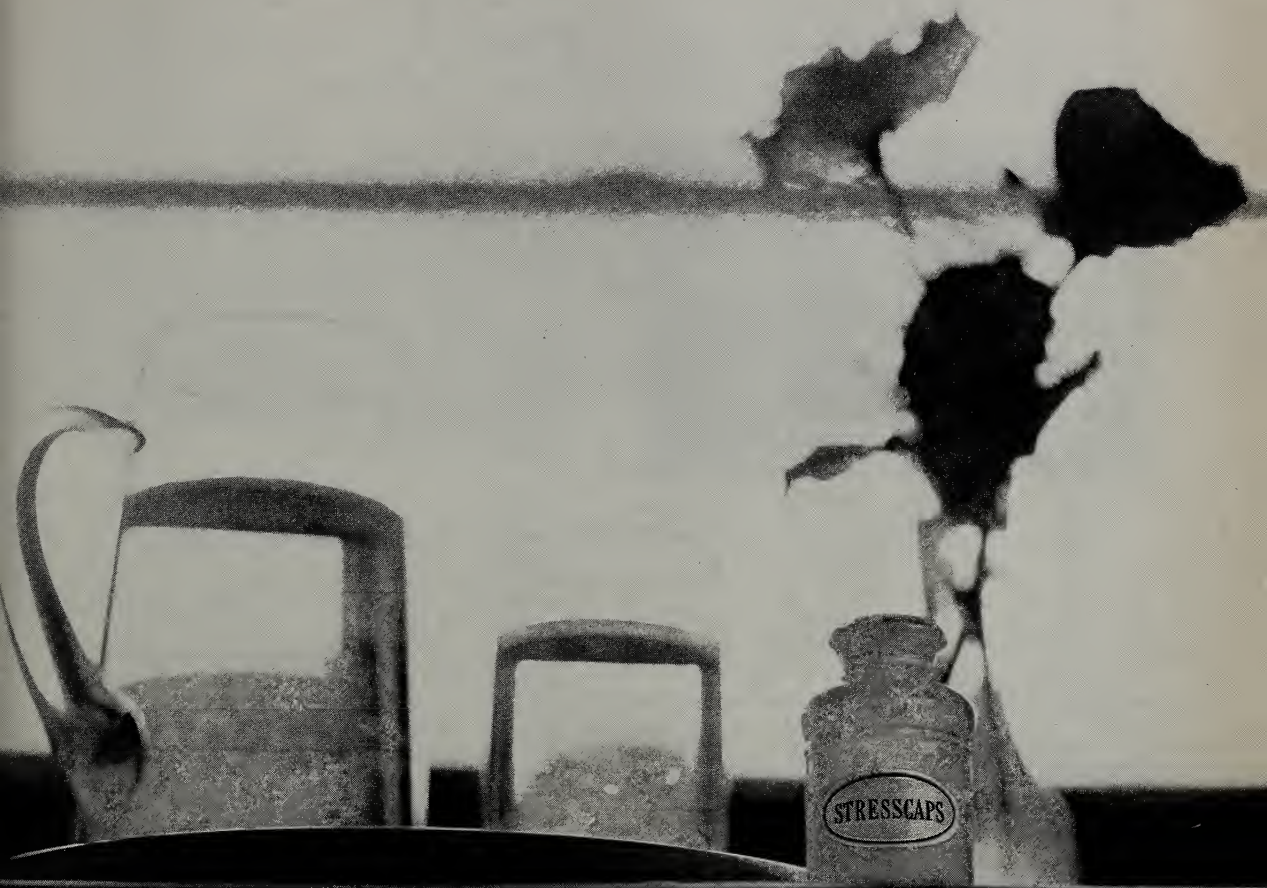
**Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

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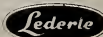
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 Vitamin B<sub>1</sub> (as Thiamine Mononitrate) 10 mg.  
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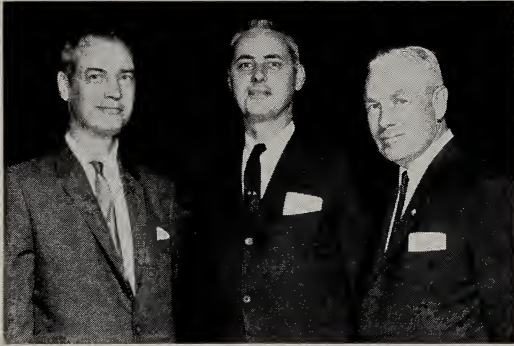
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8693-4



## Sixth District Again Excels With Outstanding Program

The impact of Medicare on the practice of medicine, the rapid developments of laser surgery, the experiments in echoencephalography, the metabolic aspects of acute infections and the increased responsibilities of an industrial medical program were



*Shown at the Sixth District Postgraduate Day meeting, from left, are Dr. Harold Bowman, Canton, Stark County Medical Society president; Dr. John MacIver, one of the speakers; and Dr. Robert E. Tschantz, Canton, Immediate Past-President of OSMA.*

among the topics discussed at the Sixth Councilor District Postgraduate Day on October 20.

The all-day seminar in the Onesto Hotel in Canton brought an excellent attendance with all six counties in the district well represented, plus numerous visitors. Presiding at the meeting was Dr. A. R. Furnas, Jr., of Massillon, and host for the event was the Stark County Medical Society, with Dr. Harold Bowman, president.

Dr. Jack Schreiber, of Canfield, a member of the AMA Speakers' Bureau, keynoted a discussion on



*Among those who attended and participated in the Sixth District Day program were, from left, Dr. Edwin R. Westbrook, Warren, Sixth District Councilor; Dr. K. W. Kitzmiller, Cincinnati, one of the speakers; Dr. Louis Loria, Bristolville; and Dr. Rex Whiteman, Warren.*

Medicare. In his talk entitled "America Is Magic," he recalled the paths of freedom in this country and

outlined steps physicians can take in regard to federal health programs.

Dr. John MacIver, assistant medical director of the U. S. Steel Corporation, discussed the responsibility to keep the industrial work force healthy, physically and psychologically as the function of a modern-day industrial medical program.

Dr. K. W. Kitzmiller, of Cincinnati, described the work being done with laser surgery at the Laser Laboratory of Children's Hospital.

Dr. G. Robert Nugent, associate professor of surgery at West Virginia University, discussed advances in the use of radioisotope scanning and echo-encephalogram in diagnosing brain lesions.

Among speakers were Dr. William R. Beisel, U. S. Army Medical Corps, who stressed the importance of diet during convalescent periods following an infectious disease; and Dr. Fred Heggie, Department of Pediatrics, Western Reserve University, who pointed out that research should soon produce a vaccine for control of German measles.

## Midwestern People Best Protected by Major Medical Insurance

More persons in the Midwest have major medical expense insurance than in any other region of the nation, the Health Insurance Institute reported.

In the 12 Midwest states — Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska and Kansas — a total of 13,639,000 persons had major medical at the end of 1964. In Ohio alone, 2,579,000 people had major medical.

Major medical helps pay for hospital and surgical care and a wide variety of other medical services in or out of hospital including prescribed medicines, and drugs, medical appliances, physicians services, charges by a registered nurse, and ambulance and other medical transportation. Benefits range to \$10,000 and often go much higher depending on the policy.

The second region in number of persons with major medical was the Northeast and its nine states with 13,497,000 persons covered followed by the sixteen states of the South and District of Columbia with 11,285,000. The 13 Western states had 8,580,000 persons with major medical protection.

The Institute reported that in the entire country last year more than 47 million persons were protected by major medical insurance provided by insurance companies. The Institute said that this number had grown to an estimated 49 million by June 1, 1965.

The Physical Therapy Curriculum of Western Reserve University has been awarded a teaching grant of \$51,000. The grant is to be used for departmental needs as well as support of the students enrolled in the Curriculum. Sponsor is the Vocational Rehabilitation Administration of the Department of Health Education and Welfare.



## M. D.'s in the News

Dr. Simon O. Ohanessian discussed quackery in medicine as speaker for the annual business meeting of the Geauga Unit of the American Cancer Society held in Chardon.

\* \* \*

Dr. Donald E. Hughes, pathologist at Van Wert Hospital, was guest speaker at an executive board meeting of the Defiance Chapter, American Cancer Society, at which he gave an illustrated review of cancer prevention.

\* \* \*

Dr. T. A. Makley, Jr., chairman of the Department of Ophthalmology at Ohio State University College of Medicine, was guest speaker for the annual meeting of the Guernsey County Cancer Society, where he discussed cancer from the standpoint of the ophthalmologist.

\* \* \*

Dr. Robert E. Reiheld, Orrville, was named head of the citizens education committee to promote passage of a levy to further the building program for local schools.

\* \* \*

Dr. Thomas W. Watkins, Tiffin, addressed the Family Circus League of Fremont, an organization for mothers of small children. Dr. Watkins discussed diet, feeding and discipline of children and stressed such health measures as proper immunization.

\* \* \*

Dr. Robert D. Gillette, Sandusky, spoke on "The Use of the Pacemaker and Other Resuscitation Techniques," at the Erie-Huron District meeting of the Ohio State Nurses Association.

\* \* \*

Dr. R. Vance Fitzgerald, Toledo, spoke on "The Relationship of Psychiatry and Law," at the first of a series of law institute luncheons sponsored by the Toledo Bar Association.

\* \* \*

Dr. R. K. Bartholomew has been named director of medical education at Miami Valley Hospital, Dayton.

\* \* \*

Dr. A. Clair Siddall was named "man of the year" by the *Oberlin News-Tribune*.

\* \* \*

Three physicians in the field of obstetrics and gynecology presented the second Alven M. Weil Memorial Lectureship at Akron City Club recently. They are Dr. Kenneth J. Ryan, Western Reserve University School of Medicine; Dr. Robert W. Kistner, Harvard Medical School; and Dr. Nicholas Vorys, Ohio State University College of Medicine. They discussed use of modern drugs in obstetrics and gynecology.

## New Members . . .

Following are names of new members of the Ohio State Medical Association certified to the Columbus office during October. The list shows county in which new member is practicing or temporary address in the case of a physician taking graduate work.

### Clark

Francis A. Gruszka, Springfield

### Cuyahoga

Richard T. Johnson, Cleveland  
Norman W. Lavy, Cleveland  
Michael J. Stianche, Cleveland

### Franklin

James N. Allen, Columbus  
Ronald B. Berggren, Columbus  
Harvey M. Friedman, Columbus  
Jan W. Gregory, Columbus  
Thomas D. Moore, Columbus  
Robert A. Weisenburger, Columbus

### Gallia

Josef Klesal, Gallipolis

### Greene

H. Eugene Curley,  
Yellow Springs

### Hamilton

Salomon Abas, Cincinnati  
Thomas E. Brown, Cincinnati  
August J. Cassini, Cincinnati  
Richard H. Charles, Cincinnati  
Emmett Conyers, Jr., Cincinnati  
Ronald Drasnin, Cincinnati  
Sheldon Farber, Cincinnati

### Hamilton (Continued)

Ronald H. Fegelman, Cincinnati  
John C. Fenton, Cincinnati  
Darrel Dean Gant, Cincinnati  
Evelyn V. Hess, Cincinnati  
James L. Hull, Cincinnati  
Harold E. Johnstone, Jr., Cincinnati  
Richard S. Kerstine, Cincinnati  
George M. McClung, Cincinnati  
Ernest H. Meese, Cincinnati  
Joseph B. Paley, Cincinnati  
William R. Richardson, Cincinnati  
Robert W. Ritz, Cincinnati

### Licking

John W. Houser, Newark  
Harold E. Kelch, Newark

### Lorain

Thomas Sfiligoj, Lorain

### Medina

Gilbert F. Fisher, Jr., Lodi  
Constantine Jamoulis, Wadsworth

### Montgomery

Lawrence R. Koehler, Dayton

### Wood

George R. Woods, Rossford

## Medic Alert Foundation Urges Use of Emblematic Tag

More than 140,000 persons are now wearing Medic Alert Emblems, issued by the Medic Alert Foundation International, a nonprofit organization dedicated to educating and encouraging individuals to wear on their persons identification of any medical problems that should be known in an emergency.

The Medic Alert emblem shows on one side any medical problem such as "Diabetes," "Allergic to Penicillin," etc. Also engraved on the tag is the telephone number where information about the patient may be obtained.

The foundation maintains a central file accepting on a 24 hour basis, collect calls from anywhere in the world, relaying information from the file pertaining to the wearer. A nominal fee is charged for the patient's registration and his emblem.

Additional information may be obtained by writing The Medic Alert Foundation International, Turlock, California; Marion C. Collins, M. D., President.

Dr. Alexander F. Robertson, assistant professor of pediatrics at Ohio State University College of Medicine, has been awarded a \$50,000 grant from the U. S. Public Health Service to support his investigation of lipid metabolism in the human placenta.

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## new from Ames 5 basic uro-analytical facts in 30 seconds

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REAGENT STRIPS

### ...broadest urine screening possible from a single reagent strip

Urine test results with LABSTIX Reagent Strips can represent significant guides to differential diagnosis or therapy in many conditions. An unexpected "positive" may enable you to detect hidden pathology—long before more recognizable symptoms become evident. Negative results, which permit you to rule out abnormalities in a broad clinical range, can serve as baseline values for reference in future examinations. The 5 colorimetric test areas encompassed on LABSTIX Reagent Strips are:

**pH**—values are read numerically in the essential range of pH 5 to pH 9.

**Protein**—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

**Glucose**—provides a "Yes-or-No" answer for urine "sugar spill."

**Ketones**—detects ketone bodies in urine—both acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

**Occult Blood**—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

### Now a Clear Reagent Strip of Firm Construction

...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle).



Ames Company, Inc., Elkhart, Indiana

AMES





## An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

**Indications:** 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

**Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

**Precautions:** Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may

## Miltown® (meprobamate)

possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very

rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

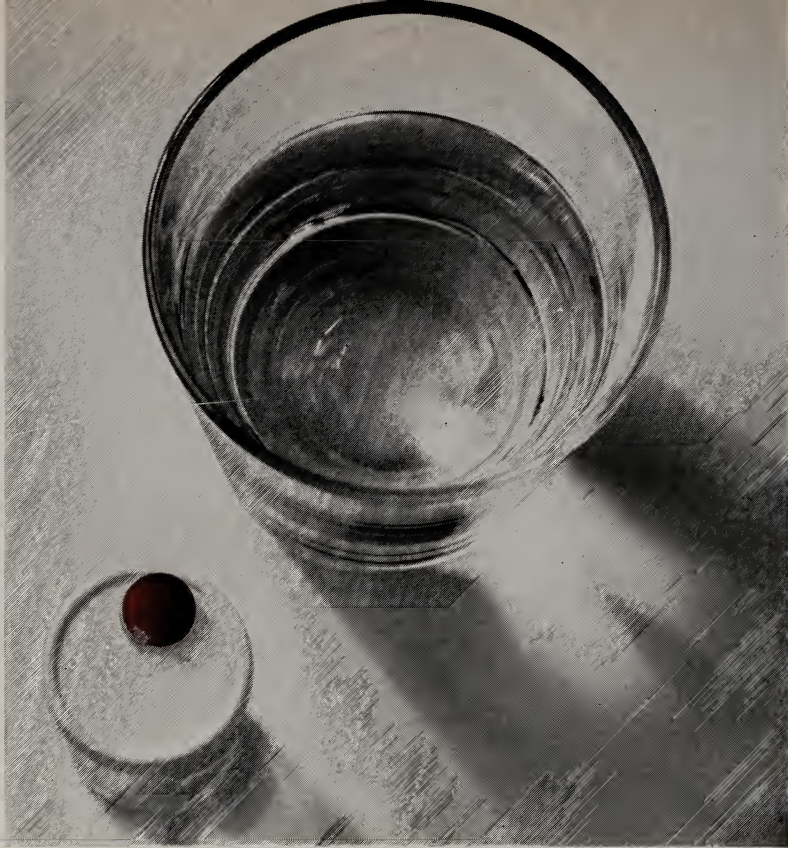
**Supplied:** In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

*Before prescribing, consult package circular.*

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Cranbury, N.J.

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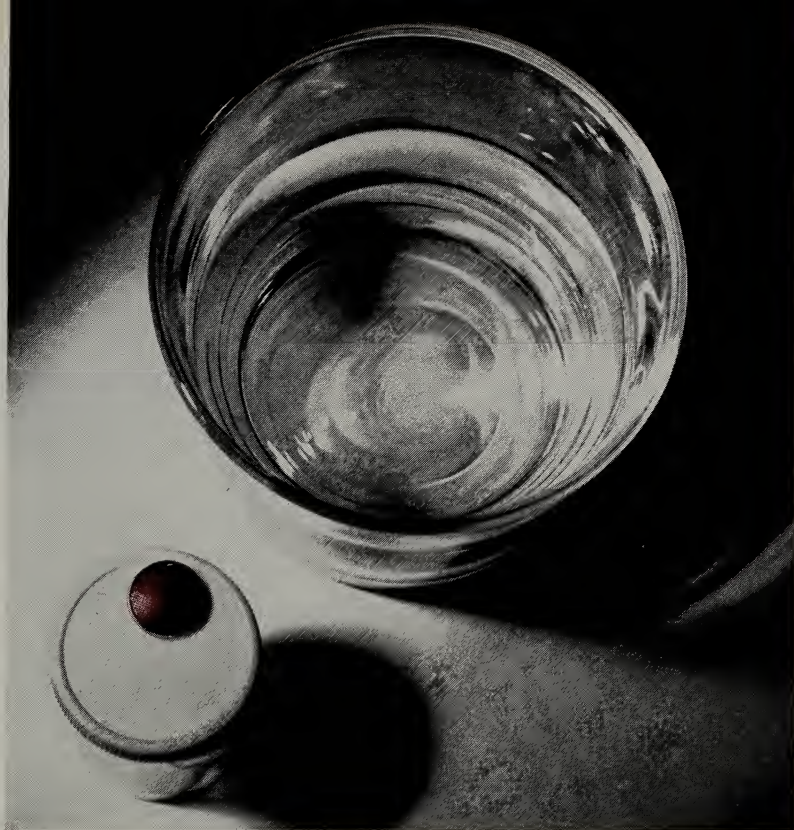


**one mid-morning**

# **New 300mg tablet**

**For Adults**—2 tablets provide a full 24 hours of therapy...with all the extra benefits of DECLOMYCIN...lower mg intake per day...proven potency...1-2 days' "extra" activity to protect against relapse or secondary infection.





**one mid-evening**

**It's made for b.i.d.**

**DECLOMYCIN<sup>®</sup>**  
**DEMETHYLCHLORTETRACYCLINE**  
**300mg FILM COATED TABLETS**

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Side effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea,

vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short

exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Tablets: 300 mg of demethylchlortetracycline HCl.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

655-1355



# Do You Know? . . .

Linden F. Edwards, Ph. D., educator of long standing and former chairman of the anatomy department at Ohio State University, was named professor emeritus in September. Dr. Edwards, who received the OSU Distinguished Teaching Award in 1964, is a noted historian, among his other accomplishments. He has contributed numerous historical articles to *The Ohio State Medical Journal*.

\* \* \*

Dr. Kenneth W. Clement, Cleveland, has been appointed to the National Selective Service Appeal Board.

\* \* \*

Dr. Richard D. Burk, director of the Ohio Rehabilitation Center at Ohio State University, has resigned his post in Columbus to accept a position as chairman of the Department of Physical Medicine at the University of Texas Southwestern Medical School, Dallas.

\* \* \*

Dr. Martin D. Keller, associate professor of preventive medicine at Ohio State University College of Medicine, is heading a survey team to screen potential heart disease patients in the Dayton and Columbus areas. With the backing of the U.S. Public Health Service, the survey team anticipates screening out perhaps 500 "coronary prone" men out of some 20,000 to be tested, with a five-year follow-up program.

\* \* \*

Dr. Gerald T. Kent reported on results of a survey of 150,000 persons in the Cleveland area before a scientific meeting of the Diabetes Association of Greater Cleveland.

\* \* \*

Dr. Robert M. Zollinger, professor and chairman of the Department of Surgery at Ohio State University College of Medicine, has been inducted as an honorary fellow of the Royal College of Surgeons of England. He also received an honorary doctorate from the University of Lyon, France.

\* \* \*

Dr. Paul A. Nelson, Cleveland, editor of Archives of Physical Medicine and Rehabilitation, and head of physical medicine and rehabilitation at the Cleveland Clinic, received the "Golden Key," highest honor of the American Congress of Physical Medicine and Rehabilitation, at that organization's recent convention in Philadelphia.

\* \* \*

The International Dag Hammarskjöld Prize — a Grand Collar with Gold Medal for Human Merit — was bestowed in absentia on Dr. Albert B. Sabin, Cincinnati, developer of the oral polio vaccine which bears his name. Dr. Sabin was selected by the International Association of the Diplomatic Corps for the honor bestowed in Venice, Italy.

**Description:** Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-72 hours) and low toxicity. It is not a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.

**Indications:** Hypertension and many types of edema involving retention of salt and water.

**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.

**Warning:** With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.

**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

**Average Dosage:** One tablet (100 mg.) daily with breakfast.

**Availability:** Tablets of 100 mg. in bottles of 100 and 1000. For full details, see the complete prescribing information.

## Hygroton®

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The long-acting  
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# Scientific Section

VOL. 61

DECEMBER, 1965

No. 12

## Gastric Cancer

### A Survey of Five Hundred and Seventy-four Cases

JAMES W. KELLER, M.D., and DAVID L. KINSEY, M.D.

ALTHOUGH deaths caused by carcinoma of the stomach have steadily decreased, this malignant tumor remains the fourth most common cancer. Its death rate is exceeded only by that of lung, intestine, and breast cancer. Editorial emphasis on this decreased incidence has revived interest in all aspects of the problem, with a consequent expansion of recent literature on the subject. There have been many excellent clinical and interpretive reviews,<sup>3,4,11,12</sup> epidemiologic studies, and a new text.<sup>5</sup> Comparison of the results of treatment at different clinics affords broader insight into problems of diagnosis and treatment of this enigmatic entity. This report is a survey of our experience with gastric cancer at The Ohio State University Hospital. It is not meant to reveal any startling innovations in diagnosis or therapy, but will provide another parameter for comparison.

#### I. Materials and Methods:

Between 1940 and 1962, a total of 574 histologically proven cases of gastric cancer were seen at The Ohio State University Hospital. Complete follow-up data were available on 566 cases as of December 31, 1963. For the purpose of this study the remaining eight patients were assumed to be dead from the time of their last known contact. The data from the case records of these 574 patients serve as the basis for this report.

#### The Authors

- Dr. Keller, Columbus, is a Resident in Surgery, University Hospitals; Instructor in Surgery, The Ohio State University College of Medicine.
- Dr. Kinsey, Columbus, is Assistant Professor, The Ohio State University College of Medicine.

#### II. Clinical Data

##### Age, Sex, and Race

There were 423 males and 151 females in the series (Table 1); this conforms closely to the re-

TABLE 1. Sex and Race

	No. Cases	Per Cent
White Male .....	344	59.6
White Female .....	134	23.2
Negro Male .....	78	13.5
Negro Female .....	17	3.5
Japanese Male .....	1	0.2

ported 2-2.5:1 male to female incidence frequently quoted.<sup>1</sup> Caucasians outnumbered Negro patients 478 to 95, a ratio which approximates that of our total hospital admissions.

Four of the patients were under 30 years of age. The youngest patient was 25 and the oldest 90. As would be expected, the majority of patients were from 50 to 80 years of age, with the highest incidence in the seventh decade (Fig. 1). This is in

From the Department of Surgery, The Ohio State University Hospitals, Columbus, Ohio. Submitted March 9, 1965.

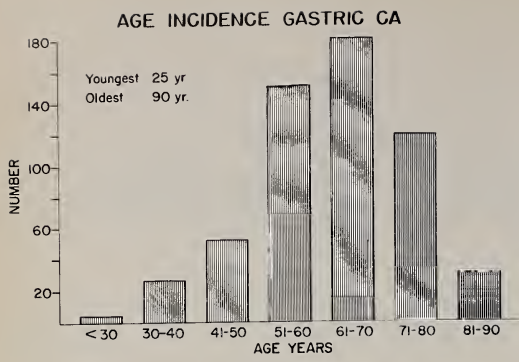


FIGURE 1

close accord with age frequency as reported in other series.<sup>6,7</sup> The modal age for the group was 64 and the mean 62.6.

### Symptoms

Abdominal pain and anorexia are the two most common and early symptoms of gastric cancer (Table 2). They may not indicate an early stage of the

TABLE 2. Symptoms

	No. Cases	Per Cent
Abdominal Pain .....	200	34.8
Anorexia .....	185	32.2
Distension, Bloating .....	127	22.1
Dyspepsia .....	127	22.1
Weight Loss .....	115	20.0
Vomiting .....	77	13.4
Bleeding .....	44	7.7

disease, as many lesions are far advanced when first symptomatic. In addition, these symptoms may be so mild that diagnostic procedures are delayed. Persistent vomiting, hematemesis and melena are less frequent symptoms but are so distressing, that they necessitate earlier diagnostic evaluation. Vague "dyspepsia" and distension are frequent complaints but so nebulous that neither the patient nor the doctor is seriously concerned about them.

Table 3 shows the duration of symptoms prior to diagnosis. The shortest interval was one month and

TABLE 3. Duration Symptoms

	No. Cases	Per Cent
0-6 months .....	355	61.8
7-12 .....	150	26.1
13-18 .....	26	4.5
19-24 .....	34	5.9
>24 .....	9	1.7

the longest six years. It is doubtful that a patient could have symptoms caused by gastric cancer for a six-year period, but this does demonstrate how long significant abdominal complaints may be present before some physicians finally resort to readily available radiographic evaluation. However, in nearly two thirds of all patients, symptoms persisted no longer than six months prior to diagnosis.

It is interesting that patient survival, as related to symptoms, was nearly the same for all complaints

other than dyspepsia. The five-year survival rate for patients with this complaint was over 10 per cent, while in the over-all series this rate was closer to 5 per cent. Vague abdominal complaints probably occur earlier in the illness than do definite pain or vomiting. The presenting symptoms showed no correlation to location of the lesions; nor did they vary with duration of the illness.

Although only 115 patients complained of weight loss, questioning showed that two thirds of all patients had lost over 10 pounds (Table 4). Of these

TABLE 4. Weight Loss

	No. Patients	Per Cent
None .....	36	6.3
1-10 lbs. ....	45	7.8
11-20 lbs. ....	129	22.5
21-35 lbs. ....	132	23.0
>35 lbs. ....	115	20.0
Amount Unknown .....	117	20.4

patients, 247 lost more than 20 pounds each. The duration of the illness had no apparent relation to the amount of weight loss. Survival time was similarly unrelated to this factor except that no patient who lost over 35 pounds lived more than 24 months after the diagnosis was established.

### Origin and Size of Lesion

Data were insufficient in 110 patients to allow adequate localization of the lesion. Of the other patients, the lesion was in the fundus or esophago-gastric junctions in 112, in the body in 106, in the antrum in 109, and in the prepyloric region in 96. In the remaining, the lesion was diffuse or multifocal (Fig. 2). The antrum and prepyloric region were

### ORIGIN OF LESION 423 CASES

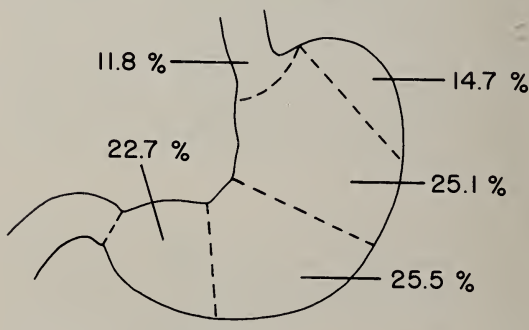


FIGURE 2

separated because of their prognostic significance, as will be shown later.

The size of the lesion was described in 311 patients. Of these, 58.5 per cent were over 6 cm. in diameter and 41.5 per cent under 6 cm. (Table 5).



TABLE 5. *Size Lesion 310 Patients*

	No. Patients	Per Cent
0-2 cm .....	19	6.1
2-4 cm .....	37	11.9
4-6 cm .....	73	23.5
>6 cm .....	181	58.5
Total .....	310	100.0%

The lesion was under 4 cm. in diameter in only 18 per cent of these patients.

### Laboratory Findings

Significant anemia (hemoglobin less than 10 grams per 100 ml.) existed in 177 patients at the time of diagnosis (Fig. 3). Twenty-nine patients had a

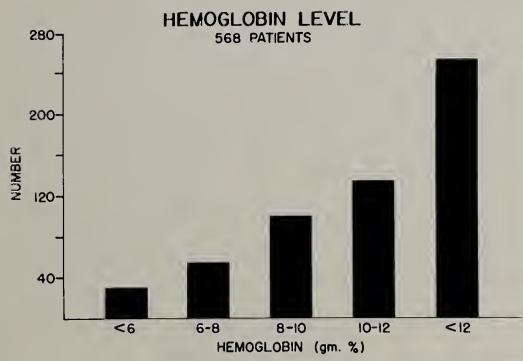


FIGURE 3

hemoglobin level below 6.0 grams per 100 ml. but nearly three fourths of all patients had normal blood indices. No patient with hemoglobin below 6.0 grams survived beyond 30 months after diagnosis. This accents the known poor prognosis in severely anemic patients.

Blood urea nitrogen levels were normal (<15 mg. per 100 ml.) in one half of 523 patients on whom the test was made. In 224 patients it was between 16 and 30 mg. per 100 ml., and varied from 30 to 90 mg. per 100 ml. in the remaining 53. A poor prognosis was associated with nitrogen retention in excess of 50 mg. per 100 ml.; no patient lived over three years with such poor renal function. Again, this amount of nitrogen retention appears to be a measure of general debility.

Gastric analysis for acid was done in 243 patients. Fifty-five per cent (129) of the patients demonstrated histamine achlorhydria, a figure much lower than that reported by other authors.<sup>6,8</sup> However, 52 patients had definite peptic ulcer disease in the past; 24 duodenal, 26 gastric, and 12 in undetermined sites. This incidence is probably coincidental and unrelated to the subsequent development of cancer.

Contrast gastrointestinal radiography was performed in 471 of these patients at our hospital; the remaining patients had had radiographic evaluation elsewhere. Of these 471 patients, 14 per cent were found to have diffuse infiltrative changes (Table 6).

TABLE 6. *Radiographic Findings 471 Cases*

	No. Patients	Per Cent
Obviously Carcinoma .....	168	35.7
Probably Carcinoma .....	184	39.1
Obviously Benign Ulcer .....	15	3.2
Probably Benign Ulcer .....	41	8.7
Other .....	63	14.3

In an additional 75 per cent the lesions were interpreted as malignant. "Benign" ulcerative lesions were seen in 56 patients; this 12 per cent error is commonly accepted as unavoidable.

### Treatment

Nearly 80 per cent of the patients underwent operation (Table 7). In 222 a curative operation

TABLE 7. *Type of Operative Procedure*

	No. Patients	Per Cent
Subtotal gastrectomy .....	146	25.4
Total gastrectomy .....	12	2.1
Radical gastrectomy .....	64	11.1
Gastroenterostomy Bypass .....	63	10.9
Feeding jejunostomy .....	30	5.2
Exploration and Biopsy .....	135	23.5
Total .....	450	78.2%
No Surgery .....	124	21.8%
	574	100.0%

was performed, while in 228 either a palliative operation or exploration and biopsy alone was performed. Widespread disease or refusal by the patient were the only reasons for not undertaking surgery in the remaining 124 cases.

Of the curative resections, 153 were either total or radical total procedures. In the entire group of curative operations there were 25 deaths for a mortality rate of 11.3 per cent. This compares favorably with the figure reported by others.<sup>6,7</sup>

There were 22 deaths in the 228 palliative operations—a mortality rate of 8.3 per cent. One hundred fourteen patients had exploration and biopsy only, the others had attempted palliation through gastroenterostomy or feeding jejunostomy or gastrotomy. The palliation thus obtained was minimal and did nothing to prolong life, as will be mentioned later.

Table 8 lists the complications by systems according to palliative and curative operations. Ninety pa-

TABLE 8. *Number of Complications*

	Operation	
	Curative	Palliative
Gastrointestinal .....	76	29
Pulmonary .....	34	24
Wound .....	16	11
Cardiovascular .....	16	9
Urinary Tract .....	8	6
Other .....	5	3
Total .....	155	82

tients who underwent curative resections had 155 separate complications; 55 patients who had palliative operations had 90 complications. It is interesting that

the relative frequency of complications by systems is similar for the two groups. The specific complications however, are different. Twenty-two patients in the curative group had leaking suture line and 27 had peritonitis or subphrenic abscess. The corresponding numbers in the palliative group were 5 and 8 respectively. Eight patients in the curative group and one in the palliative had postoperative pancreatitis. Pancreatitis following gastric resection is expected in any large series and this incidence is actually low.

Pulmonary complications are a frequent cause of postoperative morbidity in all upper abdominal surgery. Pneumonia occurred in 16 patients after gastric resection, and atelectasis in 14; these complications numbered 12 and 10 respectively in the palliative procedures.

There were four patients in each group with wound dehiscence. Eleven patients in the curative group and six in the palliative had wound infections. Cardiovascular complications were relatively infrequent as were those in the genitourinary system.

### Survival

Survival rates were figured yearly for 1-5 years following diagnosis. In an attempt to establish prognostic criteria, the attrition rate was related to all known variables for which information was available. Sex and age at diagnosis had no relation to survival except that the very young and very old generally have a poor prognosis. Presenting symptoms had little relation to survival. Weight loss, anemia, and blood urea nitrogen values were irrelevant unless they were severely abnormal, thus indicating general debility or widespread disease. A slight difference in racial survival rate was present, for at one year there are 30 per cent survivals in the Caucasians and only 19 per cent in the Negroes. However, five-year survival rates were essentially identical in the racial groups — near 5 per cent.

The over-all survival rate for the 574 patients was 4.7 per cent (Fig. 4). There was one survival

procedures lived five years — a 1.8 per cent rate. It is amazing that any patient in either group lived so long; this is probably a reflection of low grade malignancy or "spontaneous regression" — if such occurs in gastric cancer. The year by year survival rates of the non-operated patients and of those undergoing palliative procedures paralleled each other closely. This observation clearly illustrates the difficulty in helping the advanced case of cancer of the stomach.

Twenty-two of the 222 patients operated on for cure survived five years — a 10.4 per cent rate. This is less than the 15 to 30 per cent reported by other authors,<sup>6, 7, 9, 10</sup> although their figures do not include postoperative mortalities, as ours do. The benefit of extended surgery is more readily recognized when comparing the survival rates at the first and third postoperative years. Thus 52.7 per cent of the patients in the curative group were alive at the end of one year and 20 per cent at three years. These survival figures are 10 and 2 per cent respectively in the palliated patients.

A study of the curative resections according to presence or absence of nodal metastases and direct extension of the tumor shows some striking differences in survival rate (Fig. 5). There is little dif-

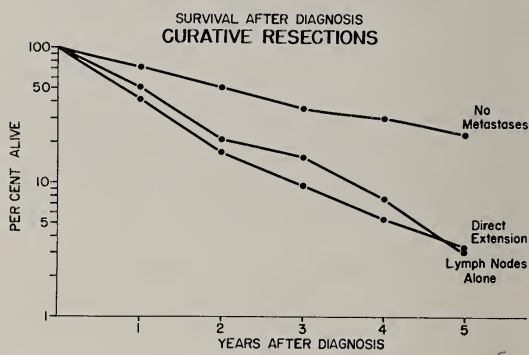


FIGURE 5

ference in longevity in direct extension of the tumor or in the presence of local lymph node deposits. The rate at five years is 3 per cent in each instance. However, when the tumor is localized, both grossly and microscopically, the five year survival rate nears 23 per cent.

Figure 6 shows the survival curves according to type of anastomoses performed after gastric resection. The poor rate for the esophagojejunostomy is undoubtedly related to the poor general prognosis for lesions around the esophagogastric junction. With more distal lesions, a subtotal gastrectomy is more often done and esophagojejunostomy accordingly is infrequently employed. The difference in survival rate between Bilroth I and II type anastomoses is related to many variables. Probably the most important is the reason for doing the Bilroth II. In

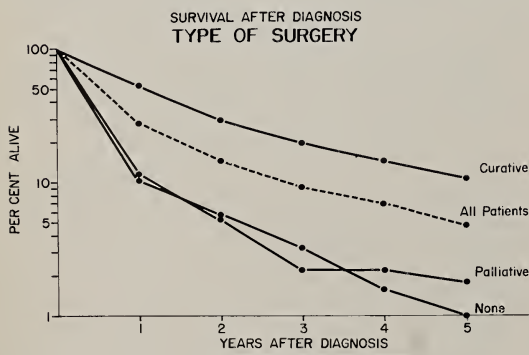


FIGURE 4

among the patients not undergoing surgery, a rate of 0.8 per cent. Only four patients who had palliative



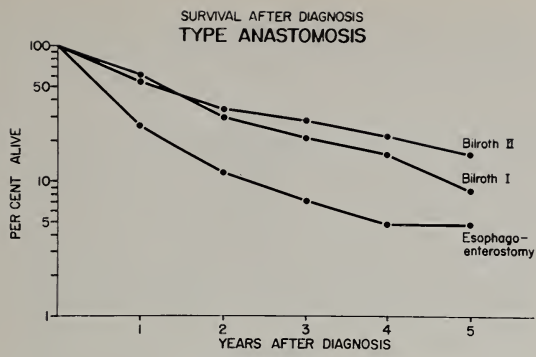


FIGURE 6

our hospital a Bilroth I is nearly always employed "when possible"; if technically unfeasible because of difficulties in mobilizing the duodenum, then a Bilroth II is resorted to. Thus the antral lesions with local extension around the pancreas would probably require Bilroth II anastomoses. Other variables are the greater morbidity and an increased mortality associated with the Bilroth II procedure.

The size of the lesion and its location similarly affected the survival rates. The survival rate for all lesions less than 6 cm. was nearly equal. However, when these are compared to lesions over 6 cm. there is a definite difference in survival rate (Fig. 7). The

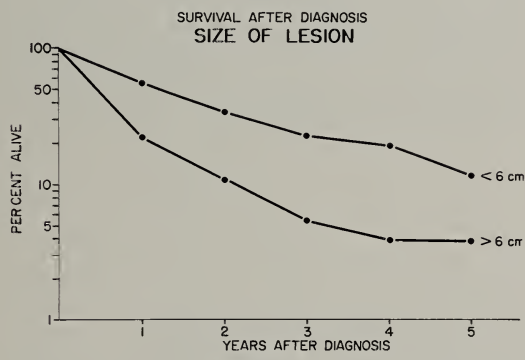


FIGURE 7

year by year survivals over a five-year period are from 2 to 4 times greater for the smaller lesion.

Location of the lesion has long been known to affect survival rates. There are few reported survivals over five years when the lesion has been at the esophagogastric junction, and in our series only 1 of 50 patients so survived (Fig. 8). Lesions in the antrum allowed the best prognosis, with approximately a 9 per cent five-year survival in the 109 patients with lesions here. This drops to 6 per cent for lesions around the fundus or corpus.

### III. Discussion

It is universally accepted that early surgical intervention offers the only hope of cure in gastric cancer. In agreement with the findings of other

investigators,<sup>7,13</sup> our over-all survival rate at five years post diagnosis was approximately 5 per cent, an admittedly dismal figure. The prognosis for gastric cancer is not completely hopeless, however. This is indicated by the fact that the survival rate

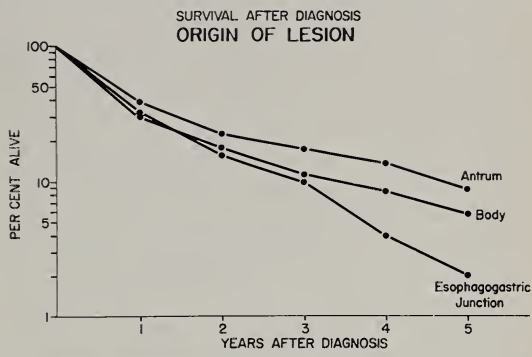


FIGURE 8

is more than quadrupled for early resectable lesions. Delay in diagnosis, whether by patient or physician, permits perpetuation of tumor growth and propagation of metastases, thus preventing surgical extirpation of the disease.

Recent emphasis on the decreasing incidence of gastric cancer has revived interest in this disease. This has resulted in new diagnostic techniques such as tetracycline fluorescence of gastric lesions and analysis of gastric aspirate for enzyme content. But if a diagnostic test is to be of value it must be used: the single most formidable obstacle to diagnosis is still delay. Complaints which might be relative to gastric cancer, such as vague epigastric discomfort or dyspepsia, must be viewed with suspicion in patients over 50 years of age. Information gained from surveying our patients corroborates that of other investigators who find significant anemia and achlorhydria in 50 to 75 per cent of patients with this malignant tumor. With these findings, the physician should feel obligated to obtain upper gastrointestinal radiography which has an 85 per cent diagnostic accuracy.

Treatment after diagnosis must be individualized, but operation for cure, either by total or subtotal gastrectomy must be done if at all possible. Total extirpation of the lesion, including its extension into colon or omentum, is advised by many; the consequent increased survival rate<sup>7</sup> indicates its merit. What appears at surgery to be direct tumor extension to contiguous organs frequently proves to be inflammatory reaction microscopically; hence gross appearance at laparotomy should not be enough to deter the surgeon from a planned direct attack on the lesion. Nearly all recent reports have emphasized the increasing applicability of gastrectomy and radical gastrectomy; coexistent with this there has been a similar rewarding rise in survival statistics. For the distal antral and prepyloric lesions, a subtotal

gastrectomy and lymph node dissection will afford adequate treatment and yield survival statistics comparable to total gastrectomy in similarly located lesions.

When curative resection is not possible, due to liver or distant metastases, the surgeon's decision is more difficult. The procedure is then reduced to a palliative one, but true palliation is seldom achieved. In obstructing antral or pyloric lesions, significant relief may be allowed through bypass gastroenterostomy. However, the insertion of Mackler tubes or similar apparatus for lesions at the esophagogastric junction is rarely beneficial and certainly doesn't prolong life. Feeding gastrostomy or jejunostomy for similar lesions has afforded minimal symptomatic improvement; it is naïve to hope that these operations will help the patient regain weight and stamina if a nonresectable cancer remains. Increased longevity should not be sought through palliation. In our series the year by year survival rates for patients having no surgery and those having palliative procedures are parallel, with nearly identical one year figures of 11 per cent decreasing to 1 per cent at five years.

Analysis of various factors as they relate to prognosis in this series shows close correlation to results published by others. Thus, the size of the primary lesion and its location seem to have considerable bearing on survival. Increasingly larger lesions are more frequently associated with serosal involvements and with liver and lymph node metastases, with subsequent poor prognosis. Lesions near the cardia and esophagogastric junction seem to spread earlier and more widely than those in the antrum or pyloric

region. Other factors such as age, sex, or race do not affect the survival so noticeably; neither do the presenting symptoms nor their durations.

### Summary

The case records of 547 patients with carcinoma of the stomach have been reviewed. All available data have been analyzed for prognostic significance. The over-all five-year survival rate of 4.7 per cent points out the poor prognosis of this disease. Early surgical intervention with radical total or subtotal resection appears to offer the only hope of cure in this disease.

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**INFECTION OF URINARY TRACT.** — An unselected group of 130 patients with symptoms of an acute infection of the urinary tract have been studied from general practice. Only 77 (59 per cent) of these 130 patients had infected urine. Treatment with sulphafurazole was possible in 72, and was effective in 57 (79 per cent of those treated). A high incidence of infection observed in young women was apparently related to sexual activity rather than child-bearing.

Of the patients with symptoms suggesting acute infections of the urine 41 per cent had urine free of infection on culture. These patients were regarded as having the "urethral syndrome."

Adequate follow-up was possible in 115 (85 per cent) of the patients; infection persisted or recurred in the three months after treatment in 25 out of 69 patients with initial infection. Bacilluria developed in the same period in 13 out of 46 patients without initial infection. Similarities between the patients with and without definite infection in the initial urine suggest that the "urethral syndrome" represents infection confined to the urethra and adjoining glands. This syndrome is part of the spectrum of infections of the lower urinary tract. — D.J.A. Gallagher, M.B., M.Med.Sc., et al.: *British Medical Journal*, Vol. 1, 622-626, March 6, 1965.



# Prematurity and Cerebral Palsy

WILLIAM BERENBERG, M.D.

WE HAVE so frequently come to regard normal birth as a physiologic process that we often lose sight of the tragic aftermath of obstetrical abnormalities. In 1861, Little<sup>1</sup> drew attention to "The influence of abnormal parturition, difficult labor, premature birth, and asphyxia neonatorum on the mental and physical condition of the child especially in relation to deformities." This syndrome evolved through a variety of designations including Little's disease, obstetrical palsy, birth injury and subsequently cerebral palsy. Several of these terms had an unpleasant implication, since they suggested to the lay public an etiology by obstetricians rather than an obstetrical etiology. Pediatricians should be anxious to avoid such a slur on their obstetrical brethren. However, it is appropriate to expect the obstetrician to be vitally concerned with the prevention of this syndrome especially since the overall incidence of prematurity (birth weight under 2500 Gm.) in association with cerebral palsy appears universally high (Table 1).

TABLE 1. *Percentage of Incidence of Prematurity in Cerebral Palsy*

Illingworth <sup>2</sup> .....	34
Roboz <sup>3</sup> .....	30
Eastman <sup>4</sup> .....	31
Steer <sup>5</sup> .....	29

The cerebral palsy problem is of special concern because of its frequency. There are approximately 4 million infants born annually in the United States. Of these, it is estimated that 1 in 1000 (0.1 per cent) suffers from overt cerebral palsy while an additional 3 per cent have some type of significant brain damage. McDonald<sup>6</sup> in a review of 1081 infants weighing less than 4 pounds at birth found that 6.5 per cent developed cerebral palsy. It would appear evident that the incidence of cerebral palsy in newborns weighing 4 pounds or less is 60 times that encountered in liveborn infants of all weights.

Clifford,<sup>7</sup> in reviewing 44,850 live births from 1943 to 1963, notes a truly significant drop in neonatal mortality over this 20 year period with the greatest reduction in the group with birth weights over 2500 Gm., while the death rate for the premature has remained essentially unchanged. He further notes an increase in premature births from 6 per cent

## *The Author*

● Dr. Berenberg, Boston, Massachusetts, is Associate Clinical Professor of Pediatrics, Harvard Medical School; Medical Director, Cerebral Palsy Unit, Children's Hospital Medical Center, Boston.

to 9 per cent during the same two decades, while the incidence of stillborn prematures has remained unchanged. It is difficult to ascribe this increase to an assumption that infants were liveborn in the latter years of this 20 year period who were previously stillborn. The explanation may lie in a more successful attack on infertility but with resultant higher frequency of decreased length of gestation. Medicine is comfortably familiar with the fact that one of the prices we pay for altering mortality is that we may increase morbidity in so doing. This is a price we expect to pay, hopefully on a temporary basis, while our tools improve.

Perhaps more surprising is the striking consistency which Clifford points out in the percentage of premature births in each weight group over a 20 year period (under 1000 Gms., 6 per cent; 1000-1500 Gms, 10 per cent; 1500-2000 Gms, 20 per cent; 2000-2500 Gms, 64 per cent.)

## *Cerebral Spastic Paraplegia and Prematurity*

Recent reports<sup>6,8</sup> have focused attention on the striking correlation between prematurity and the spastic paraplegic variety of cerebral palsy. The term, cerebral spastic paraplegia (cerebral diplegia), is used to indicate spastic diplegia of cerebral origin involving the lower extremities in unequivocal and striking disparity to minimal or absent involvement of the upper extremities.

Various authors have indicated the striking incidence of a history of prematurity in patients with this form of cerebral palsy (Table 2).

TABLE 2. *Percentage Incidence of Prematurity in Spastic Paraplegia*

Polani <sup>9</sup> .....	60
Eastman <sup>4</sup> .....	75
Berenberg <sup>8</sup> .....	70
Bandera <sup>10</sup> .....	78
McDonald <sup>6</sup> .....	81

This incidence is in striking contrast to the 29 per cent incidence of prematurity in a group of spastic

From the Children's Hospital Medical Center, Boston, Mass., and the Department of Pediatrics, Harvard Medical School.  
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quadriplegics.<sup>4</sup> From the thirtieth to the thirty-seventh week of pregnancy, each two weeks which the fetus spends in utero reduces his chance of developing spastic paraplegia by 10 per cent.<sup>6</sup> This is such a striking figure that, within the limits of safety for other reasons, every possible attempt should be made to keep the fetus in utero as long as possible up to the thirty-seventh week, when the statistical association between prematurity and cerebral palsy falls off sharply.

A significant, although less striking, association between low birth weight and the occurrence of the spastic quadriplegic and athetoid (without neonatal icterus) varieties of cerebral palsy has been noted by Alberman.<sup>11</sup>

### Clinical Features of Cerebral Spastic Paraplegia

The clinical syndrome of cerebral spastic paraplegia is well defined<sup>8</sup> and merits description because of its many distinctive characteristics. There is no significant difference in the incidence of either sex. Approximately 20 per cent seem to have more neonatal cyanosis or oxygen dependency than one would ordinarily anticipate in relation to their prematurity. These infants achieve normal motor and postural developmental milestones in their upper extremities during infancy (e. g., unclenching of hands, abduction of thumbs, grasping, reaching and holding). With the passage of time and as finer motor hand skills are expected, one often notes minor alterations of postural hand patterns or slight awkwardness. No upper extremity spasticity, exaggerated stretch reflexes, or significant hyper-reflexia is encountered. This is in striking contrast with the failure to develop trunk control (rolling over and sitting) and the ordinarily extensive spasticity of the lower extremities.

All of these patients have generalized spasticity of their lower extremities involving especially the adductor, hamstring, and gastrocnemius muscles. Subluxation of the hips is occasionally encountered. The legs often cross in a scissors posture. Tight heel cords are the rule, and contractures in this area are common.

Because of the marked lower extremity spasticity, these infants will often bear weight in a standing posture at an early age, but characteristically this is on their toes and often with legs crossed. Attempts at crawling are usually confined to efforts of the upper extremities, while the trunk remains straight with the legs in extension. Independent sitting and walking are markedly delayed. Gait, with or without support, is toe-heel in nature and usually with the hips and knees in flexion.

Knee and ankle jerks are markedly hyper-reflexic. Bilateral Babinski reflexes are the rule, and ankle clonus is common. Positive stretch reflexes are usually demonstrable in the adductor muscles and

ankles. There are no abnormalities of sensation or position sense.

Confronted with an infant born prematurely, who has such striking delay in sitting, creeping, and walking, an erroneous, early diagnosis of mental retardation is often made. Careful assessment usually reveals normal interest in environment, alertness, ability to identify, and achievement of tasks demanding upper extremity performance. Subsequent development of normal speech ordinarily comes at its anticipated time, and dysarthria is uncommon. In our own series<sup>8</sup> of 40 patients followed for a significant period, 28 were found to be intellectually adequate. Nine were borderline with I. Q.'s between 70 and 85. Three were judged mentally retarded. Psychological testing and educational challenges revealed frequent evidence of difficulty with perception, abstraction, and visuomotor coordination. Speech usually was established at normal age levels and was only rarely abnormal. No significant incidence of hearing loss was encountered.

Convulsive seizures are uncommon in spastic paraplegics, occurring in less than 5 per cent of the group. Strabismus is seen in the majority of these patients.

It is hoped that this description of the infant with spastic paraplegia so often associated with premature birth will help the clinician establish an early, accurate diagnosis. Such a diagnosis will not only permit early therapy but also a more accurate and favorable prognosis in terms of acceptable communication and adequate intellectual development.

### Summary

Cerebral palsy is a common clinical syndrome. It is frequently associated with a history of premature delivery. Cerebral spastic paraplegia merits special consideration and description because of the frequent incidence of antecedent premature birth as well as its diagnostic and prognostic pitfalls.

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# Total Blood Cholesterol

## A Simple Method of Obtaining Blood Samples And Determining the Total Cholesterol

DONALD E. YOCHEM, M.D.

THIS article describes a simple screening method that can be used in cholesterol surveys for the study of coronary heart disease. The method requires only a few drops of fingertip blood placed on a small filter paper disc, which can be mailed by envelope to a central laboratory. Cholesterol determinations are made with a micro method based on the Liebermann-Burchardt principle. This method is especially suitable for cholesterol surveys since it is not necessary to do venipunctures, and test tubes and mailing cases are not required. Furthermore, the cholesterol value can be determined after a number of samples have accumulated, or when convenient, since the cholesterol content of blood dried in filter paper does not deteriorate; and the average technician can make 50 to 75 determinations per day.

Since males accepted for life insurance appeared to be especially suitable for cholesterol studies, determinations were made on 2065 subjects 18 to 65 years of age. The cholesterol value was not used for underwriting purposes, and samples of blood were

### *The Author*

● Dr. Yochem, Columbus, is Medical Director, Nationwide Life Insurance Company. Former instructor in Clinical Medicine, The Ohio State University College of Medicine.

voluntarily submitted. This survey, which covered a period of about four years, was made (1) to test the value of the method for screening purposes, (2) to determine the cholesterol values for different age groups, and (3) to supplement, by a future report, other statistical studies of the relationship of cholesterol values and coronary heart deaths when a definitive mortality analysis is feasible.

### Materials and Method

The blood sample, obtained by piercing the fingertip, is dropped on or touched to a filter paper disc that is stapled to an ordinary white index card 3 by 5 inches. This card (Fig. 1), which must have a

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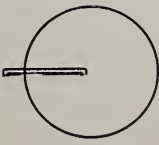
<u>CHOLESTEROL TEST</u>	
<b>FOLLOW EXACTLY FOR ACCURATE TEST:</b>	
1. Pierce fingertip as for blood counts. Obtain good flow of blood.	<div><p><b>DO NOT REMOVE DISC</b></p></div>
2. <u>SATURATE</u> disc by touching it to blood. <u>ENTIRE</u> disc must be <u>RED</u> .	
3. <u>SHAKE</u> card (3 times) as you would a thermometer to remove excess blood from disc.	
4. Place in envelope and mail to:	
Name.....	
Physician.....	
Mg.% Blood Total Cholesterol.....	

FIG. 1. Index card with directions and attached filter paper disc used to obtain sample of blood for cholesterol determination.

smooth, non-absorbing surface, provides for directions and other data, and serves as a convenient means for taking and mailing the sample.

For accurate determinations, samples must be properly taken to be certain that the correct volume of blood is absorbed by the filter paper disc. A good flow of blood must be obtained by adequate piercing of the fingertip. The filter paper must be *completely* saturated and the excess blood promptly removed. Filter paper absorbs blood up to a point where additional blood will not be absorbed even though excess blood is added. Any excess blood that would remain on the surface of the disc and increase the volume to cause error must be promptly removed by shaking the card as one shakes a clinical thermometer. After the filter paper is completely saturated with blood, even vigorous shaking of the card will not remove blood already absorbed. Thus, the filter paper retains only the limited volume of blood that its capacity permits. When the disc is properly saturated, the *entire* disc is uniformly colored and the card beneath the disc is completely colored. A disc with an elevated ridge of dried blood on the circumference indicates that the excess blood was not properly removed.

Whatman Number 4 filter paper was found most suitable because it absorbs blood more rapidly and uniformly than other filter papers tested, and cholesterol extraction from the dried blood is uniform. Volumetric studies demonstrated that a Whatman Number 4 filter paper disc *exactly* 19.050 millimeters (0.750 inch) in diameter retains 0.073 to 0.077 milliliters of adult whole blood when the disc is *just* saturated. Since different grades of filter paper absorb different volumes of blood, a Whatman Number 4 filter paper disc of the size given must be used because all calculations are based on the volume of blood retained by this disc.

### The Cholesterol Extracting Reagent

Of the many cholesterol extracting reagents tested, chloroform with ethanol proved most satisfactory because: (1) Total cholesterol is uniformly extracted from blood dried in filter paper without causing hemoglobin pigment (which causes error) to appear in the reagent, provided the water bath temperature does not exceed 52 degrees centigrade during extraction, (2) ethanol stabilizes chloroform to preserve the reagent indefinitely, (3) this reagent, plus heat, coagulates proteins in the filter paper and thereby prevents error from protein contamination, and (4) acetic anhydride and sulfuric acid can be added directly to the reagent.

### Preparation of the Cholesterol Extracting Reagent

Add exactly five (5.0) milliliters of 100 per cent (200 proof) Gold Shield ethanol (Commercial Solvents Corp.) to exactly 100 milliliters of Mal-

linckrodt analytical grade chloroform. A chemically clean and thoroughly dry amber glass bottle and cap with a *polyethylene liner* that resists the solvent action of chloroform must be used. Cap liners treated with oily or paraffin substances are dissolved by chloroform and are not acceptable. Even a trace of these substances or other contaminants or moisture in the reagent renders it unfit for use. Pipets and flasks must be chemically clean and thoroughly dry. Store at room temperature. Reagent will keep indefinitely.

### The Cholesterol Standard

The cholesterol standard was determined by comparing a number of cholesterol values obtained by this method with values obtained by the Blood method, using different standards with whole blood from the same samples. A standard containing 2.65 milligrams of pure ash free cholesterol in 100 milliliters of the extracting reagent gave cholesterol values that approximated blood total values obtained with the Blood method. This standard is based on the volume of whole blood retained by the Whatman Number 4 filter paper disc described above and is equivalent to 200 mg/100 ml total cholesterol in whole blood.

### Preparation of the 200 mg/100 ml Cholesterol Standard

Add *exactly* 2.65 milligrams of Pfanstiehl C. P. ash free cholesterol to *exactly* 100 milliliters of cholesterol extracting reagent. Greater accuracy can be attained by adding *exactly* 26.5 milligrams of cholesterol to *exactly* 1000 milliliters of extracting reagent. A chemically clean and thoroughly dry amber glass bottle and cap with a *polyethylene liner* must be used, and all glassware must be chemically clean and thoroughly dry. Shake thoroughly and store at room temperature. Standard will keep indefinitely.

### Laboratory Requirements

(1) During cholesterol extraction, the water bath temperature *must be maintained* at 50 degrees centigrade with an allowable deviation of only one or two degrees. The tube, or tubes, containing the disc is allowed to remain in the water bath for 30 minutes. At this time and temperature, extraction of the total cholesterol has been completed and reaches an end-point. Cholesterol can be extracted at lower and higher temperatures but results are not reliable. At lower temperatures the end-point of completed extraction is not constant; and at higher temperatures hemoglobin pigment, which causes error in colorimeter readings, appears in the extracting reagent.

(2) Allow at least six hours for blood to dry in the disc. If necessary, the sample can be stored for weeks or months without loss of cholesterol.

(3) Use 15 mm. diameter by 85 mm. length test tubes *without rim*.



(4) Use stoppers and glassware that are chemically clean and thoroughly dry.

(5) Use analytical grade acetic anhydride and sulfuric acid.

(6) Keep tubes and flasks *upright* to prevent reagents from touching stoppers.

(7) Regulate water bath to maintain a constant temperature of 50 degrees centigrade with no more than plus or minus *one* or *two* degrees variation.

(8) Place suitable test tube support in the water bath.

(9) Water level in water bath must be slightly above reagent level in tube.

(10) Use *extracting reagent* for blank, and set colorimeter at 100 wavelength for cholesterol.

(11) A cholesterol standard must be determined simultaneously with unknowns.

(12) Any number of cholesterol extractions can be made at the same time, depending on the capacity of the water bath and test tube support.

#### Laboratory Procedure

1. Remove disc from card with staple remover.  
2. Fold disc into halves and place in *bottom* of test tube.

3. Add *exactly* 3.0 ml. of cholesterol extracting reagent. Reagent must cover disc. Place stopper to prevent evaporation.

4. Add *exactly* 3.0 ml. of cholesterol standard to another tube and place stopper.

5. Place standard and unknowns in the water bath, which *must be maintained* at 50 degrees centigrade (plus or minus one or two degrees), for 30 minutes.

6. After 30 minutes remove tubes, wipe dry and place in rack. Time elapse between removal of the first and last tubes will not affect values.

7. Let tubes cool 5 to 10 minutes.

8. Decant *completely* the standard and unknowns into separate 50 ml. Earlenmyer flasks and place stoppers. Decant unknowns carefully to prevent disc from falling into the flask. If the disc falls into the flask, remove with clean dry forceps. *The disc must be removed from the reagent before performing the next step.* At this point the system is stable and the next step can be performed when convenient.

9. For standard and unknowns: Add *exactly* 2.0 ml. of acetic anhydride to the flask and shake laterally. Then immediately add *exactly* 0.2 ml. of concentrated sulfuric acid, place stopper and shake laterally.

10. Five (5) minutes after adding sulfuric acid, transfer to cuvette and read on wavelength for cholesterol, using extracting reagent for blank.

#### Calculation with 200 mg/100 ml Standard

Convert transmittance to optical density

$$\text{Unknown} = 200 \times \frac{\text{optical density of unknown}}{\text{optical density of standard}} = \text{mg/100 ml. total cholesterol.}$$

#### Results

Standard curve studies demonstrated good linear relationship with a maximum deviation of 1.5 per cent between optical density and cholesterol concentrations that ranged from 100 to 400 mg/100 ml.

The stability of cholesterol in blood dried in filter paper was tested by taking a series of duplicate samples. The cholesterol value in one sample was determined immediately and in the other after storing at room temperature for periods up to four months. The difference in values was no greater after four months than when both duplicates in another series were tested immediately.

Investigation proved that cholesterol is extracted from both the erythrocyte and serum portion of the blood. It was proved also that the cholesterol value of the erythrocyte remains relatively constant and that the total cholesterol value of whole blood varies according to the serum or plasma value. This finding agrees with that of Mancini and Keys,<sup>1</sup> who reported that the cholesterol content of the erythrocyte does not show significant changes even with wide variations in serum values.

Total cholesterol determinations made on duplicate fingertip blood samples taken from 40 adults yielded values that agreed within a range of 5 to 15 mg/100 ml. In additional subjects tested, it was also found that samples of venous and fingertip blood from the same subject showed no significant differences in the cholesterol value.

The total cholesterol value of whole blood was determined in 2065 life insured males 18 to 65 years of age with the method described. All determinations were made by an accredited medical laboratory. Samples of blood were obtained by physicians and were taken without relation to meals or type of food consumed. According to Best and Duncan,<sup>2</sup> the immediate nutritional state has no significant influence on serum cholesterol levels in presumably healthy subjects. However, Rosenblatt, et al.<sup>3</sup> reported that cholesterol values were higher in patients with coronary heart disease than in normal controls both at fasting and following a high fat meal.

Since space will not permit a detailed report of the statistical analysis of cholesterol studies in the insured males, only pertinent data are given.

Blood total cholesterol values of the 2065 males ranged from about 120 to 390 mg/100 ml with a mean value of 189.6 mg/100 ml. Only 20 of the 2065 values exceeded 300 mg/100 ml.

Table 1 gives the range of blood total cholesterol values in the different age groups. Table 2 gives

TABLE 1. *Cholesterol Value of Blood in Males by Age Groups*

Age (Yrs.)	Total Cholesterol in Blood, mg/100 ml										Totals
	<120	120-139	140-159	160-179	180-199	200-219	220-239	240-259	260-279	>279	
18-20	4	6	6	10	4	2	1				33
21-30	10	51	86	127	112	82	44	21	14	6	553
31-40	6	43	103	165	168	138	79	54	29	13	798
41-50	6	27	65	125	100	100	51	32	20	24	550
51-60	3	5	20	21	27	24	11	6	4	3	124
>60				1	3	2	1				7
Totals	29	132	280	449	414	348	187	113	67	46	2065

TABLE 2. *Mean, Median, and Standard Deviation of Blood Total Cholesterol in Males by Age Groups*

Age (Yrs.)	Number	Total Cholesterol in Blood, mg/100 ml		Standard Deviation
		Mean	Median	
18-20	33	158.8	172.0	27.18
21-30	553	183.0	179.0	36.98
31-40	798	191.8	208.5	37.54
41-50	550	194.5	199.7	42.58
51-60	124	190.3	167.0	39.69
> 60	7	196.1	171.0	18.95
	2065	189.6	185.5	39.00

the mean cholesterol value for each age group, and also shows the median cholesterol value and standard deviation.

Analysis of the data given in both tables showed that the age distribution is approximately symmetrical with a mean age of 36.4 years and standard deviation of 8.9. The distribution of cholesterol values also is nearly symmetrical with a mean value of 189.6 mg/100 ml and a standard deviation of 39.00.

The mean cholesterol values and standard deviation increase up to age 50. Above this age standard deviations were smaller, indicating a narrower distribution.

Correlation co-efficient of age and mean cholesterol level was 0.513 overall with 0.791 for ages up to 50 and 0.072 for ages over 50. This indicates that increasing age through 50 is generally associated with higher cholesterol values. A statistical "F" test indicates that these results could have happened by chance less than one time in 100.

Other investigators<sup>4,5</sup> reported that the mean serum cholesterol value also increases with advancing age and reaches a peak at age 60. Their serum values for the different age groups are about 10 to 20 per cent higher than the blood values given in Table 1, and their mean serum value is 17 per cent higher than the mean blood value given in Table 2. The high serum values are due to two factors: (1) serum values are higher than blood values and (2) determinations were made by a method that uses Liebermann-Burchardt reagents and does not saponify the cholesterol esters. As a result, cholesterol values were increased.

### Comments

The method of obtaining samples of blood was well accepted by the physicians who participated in this investigation, and the direct method of estimating

the cholesterol value proved especially suitable as a screening method.

Ancel Keys was first to use filter paper to obtain samples of serum for his comprehensive cholesterol studies in remote areas. His use of filter paper for this purpose led the author to investigate filter paper as a method of obtaining samples of blood for cholesterol screening purposes.

The cholesterol value of the erythrocyte remains relatively constant and the total cholesterol value of whole blood varies according to the serum value.<sup>1</sup> Therefore, blood values reflect serum values, although blood total values are somewhat lower than serum total values.

Since the method described uses Liebermann-Burchardt reagents and does not saponify the cholesterol esters, blood values are increased. Therefore, blood values reported in this study resemble serum values obtained with methods that do not use Liebermann-Burchardt reagents or saponify the esters when these reagents are used.

### Summary

A simple screening method that can be used in cholesterol surveys for the study of coronary heart disease is described. The method was used in a study of 2065 males accepted for life insurance to test the value of the method and determine the cholesterol values for different age groups. A statistical analysis of the results is documented.

The statistical relationship of these cholesterol values and coronary heart deaths will be reported when a definitive mortality analysis is feasible.

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O. J. Mottet, M.T. (ASCP) and the author developed the method described.

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# Antitussive Mixture

## A Study of the Relative Importance of Various Elements

S. WILLIAM SIMON, M.D.

NO ONE need be convinced that cough is a useful reflex. It helps to rid the airway of excessive secretions (inhalant allergens) and other irritants, thereby keeping the airway open and maintaining the integrity of the pulmonary tissues. Cough may become a serious symptom, chiefly because of its complications and sequelae. If left untreated, it perpetuates itself to the point where it may cause anorexia, vomiting, headache, syncope, insomnia, pulmonary and subconjunctival hemorrhage, heart strain and a host of other insults which the patient with chronic obstructive pulmonary disease can ill afford.<sup>1-9</sup>

For patients having asthmatic bronchitis with emphysema as well as those with cough uncomplicated by obstructive pulmonary disease, the therapeutic problem is manifold: to reduce the paroxysmal and irritative aspects of the cough reflex (centrally and peripherally), to relieve mucosal congestion and edema, to help dry secretions in the upper respiratory passages, to counter allergic aspects of the cough and to reduce the viscosity of the sputum making it easier to produce.

There are many antitussive formulae which offer the physician definite advantages. These have had a long history of use and when used as recommended are fairly safe.<sup>10-18</sup> Yet, the usefulness of these preparations may be limited in some degree by problems which arise from inadequate therapeutic effect and other factors. Fortunately, recognition of these shortcomings has stimulated the search for more effective ones.

Among the preparations recently developed which have shown interesting therapeutic potential is RORER-143, a multiple action, non-narcotic, antitussive. Its novel feature is that it provides proteolytic agents, bromelains, in addition to d-methorphan hydrobromide for specific action on the cough center; 1-phenylephrine for bronchodilator and decongestant action; homatropine methylbromide for parasympatholytic and secretion drying action; and pyrilamine maleate for antihistaminic action.

Bromelains, a concentrate of proteolytic enzymes from the pineapple plant, have been used in the treatment of edema and inflammation associated with

### *The Author*

● Dr. Simon, Dayton, is Chief, Allergy Section, and Associate Chief of Staff, Veterans Administration Center, Dayton, Ohio; Clinical Assistant Professor of Medicine, The Ohio State University College of Medicine, Columbus.

traumatic and surgical injury to tissues.<sup>19-23</sup> The rationale for the use of these enzymes in the therapy of inflammation is based on the theory that edema accompanying inflammation is due to a conversion of fibrinogen into fibrin, which occludes the capillary and lymph vessels. Bromelains, by virtue of their proteolytic action, break down these fibrin deposits, thus facilitating the return of edema fluid to the circulation, or instead may activate the native enzymes of the blood (plasminogen-plasmin system) so that the latter would react with the fibrin.

Not only plasminogen-plasmin, but still other biochemical systems may be affected in such a way as to reduce inflammation. Recently, evidence has been brought forth showing that orally administered proteolytic enzymes antagonize bradykinin, a biologically active polypeptide in blood which mediates vasodilatation, vascular permeability, smooth muscle contraction, and pain. As a component of a drug compound, bromelains may also facilitate the absorption of the antitussive agents while helping to break down large molecules of proteinaceous material in the sputum, thus easing the cough and facilitating expectoration.

### *Materials and Methods*

Fifty male patients ranging in age from 37 to 73 years and diagnosed as having asthmatic bronchitis and pulmonary emphysema were selected for study. Patients with a history of glaucoma, prostatic hypertrophy, hypertension, hyperthyroidism, cardiac disease, abnormalities of the blood-clotting mechanism, severe hepatic or renal disease were excluded from the study for obvious reasons.

The experimental design was of the double-blind, crossover type with placebo control. Five series of identical-looking coded tablets were used: (1) d-methorphan, (2) RORER-143, (3) RORER-143

without bromelains, (4) bromelains only, (5) placebo. Each series was administered in a dose of one tablet, three times daily for six days. No drug was administered on the seventh day, after which the patient was placed on crossover medication. The first drug given was randomized, but the order of administration was to be maintained.

Routine urinalysis and blood counts were carried out on each patient prior to and after the study.

After the six-day trial of each tablet, the patient was asked to report the time at which relief, if any, of his symptoms first became evident, how long relief lasted, whether sputum production was easier or harder, any change in viscosity of the sputum, whether cough was more or less severe, improvement in wheezing or shortness of breath, and which medication was preferred. The answers to these questions were recorded on the patient's report forms. If any side effects were noted, these too were described.

### Findings

Accidentally, the various tablets were re-randomized and a careful analysis of the data revealed that the order in which the various test drugs were administered introduced a bias so that each drug was not assigned an equal number of times in each sequence during the test period, as can be seen from Table 1.

TABLE 1. *Frequency of Drug Assignment*

Test Drug	Sequence					Totals
	1	2	3	4	5	
RORER-143 .....	4	14	5	10	17	50
Placebo .....	7	9	16	5	13	50

It is the sequence in which a test drug is administered, however, but that influences the patient's preference. A drug is more likely to be preferred when administered in a later than in an earlier part of the series. This is illustrated in Table 2. Preference was based on relief of wheezing, cough and shortness of breath, time of onset, length of relief and expectorant action.

TABLE 2. *Influence of Sequence on Drug Preference*

Sequence	1	2	3	4	5
Incidence of no Drug Preference	48	12	10	7	5

The opportunity to observe the effects of the bromelains added to the antitussive agents, presented itself consistently throughout this investigation and also drew attention to an item of major significance. During the study it appeared that the antitussive action of d-methorphan is reduced when 1-phenylephrine hydrochloride, pyrilamine maleate and homatropine methylbromide are added to it. With the addition of bromelains, the antitussive activity of d-methorphan was restored almost to the original level. The possibility that the concomitant medication may have influenced the patient's choice must be considered but probably neutralizes itself. The rela-

tive efficacy of the experimental tablets is reflected in Table 3.

TABLE 3. *Patient Drug Preference*

Test Drug	Frequency of Drug Preference
d-methorphan .....	14
RORER-143 .....	11
RORER-143 without bromelains .....	9
Bromelains only .....	6
Placebo .....	5
No drug .....	5
TOTALS .....	50

Further analysis of the data (not tabulated) revealed that of the 25 patients who made a drug selection between RORER-143 and placebo, 17 preferred RORER-143; seven the placebo; and one patient thought both medications were equal. Twenty patients expressed a preference for one of the three other medications employed, and five patients showed no preference at all.

Onset of relief was noted at one-half hour for all of the drugs in the study (Table 4). This is surprising in light of the fact that the medications, being enteric coated, should not have taken effect until one and a half to two hours after administration. This finding is too consistent to be attributable solely to a placebo response. It may be an effect of concomitant medication.

TABLE 4. *Onset of Cough Relief*

Test Drug	Frequency of Cough Relief within ½ to 1 Hour
d-methorphan .....	30
RORER-143 .....	27
RORER-143 without bromelains .....	26
Bromelains .....	22
Placebo .....	18

The amount of cough relief (Table 5) was most frequently noted to be between 0 and 50 per cent. It is interesting to note that the bromelains-containing combinations appear frequently in the 50 to 100 per cent cough relief column.

TABLE 5. *Amount of Cough Relief*

Test Drug	0	0-50%	50-100%	Totals
d-methorphan .....	15	27	8	50
RORER-143 .....	19	19	12	50
RORER-143 without bromelains .....	21	22	7	50
Bromelains .....	23	17	10	50
Placebo .....	28	14	8	50

The data on the duration of cough relief (Table 6) suggest that d-methorphan itself may have a longer duration of action than the combination product. The addition of the other components to d-methorphan seems to reduce both the level and duration of the antitussive's activity. The bromelains' ability to increase the permeability of tissues may also permit a more rapid excretion of d-methorphan.



TABLE 6. *Duration of Cough Relief*

Test Drug	Duration of Cough Relief in Hours					
	0	1/2-2	2-4	4-6	6	Totals
d-methorphan .....	16	3	9	5	17	50
RORER-143 .....	20	4	11	6	9	50
RORER-143 without bromelains .....	20	3	7	8	12	50
Bromelains .....	23	5	7	4	11	50
Placebo .....	27	3	5	8	7	50

The effects of various drugs tested on production and viscosity of sputum, while not dramatic, are suggestive of a beneficial effect when the noted frequencies are compared to the findings in the placebo-treated group.

TABLE 7. *Effects of Test Drugs on Production and Viscosity of Sputum*

Test Drug	SPUTUM			
	Production		Viscosity	
	Same	Easier	Same	Thinner
d-methorphan .....	17	23	26	18
RORER-143 .....	14	25	22	17
RORER-143 without bromelains .....	19	22	21	18
Bromelains .....	16	20	26	10
Placebo .....	22	18	30	9

Side effects reported were minimal (two nausea, one vomiting and one with blood-streaked nasal discharge), and did not constitute any problems to therapy.

Because of the lack of significant differences between the drugs tested with reference to wheezing and shortness of breath, the data are not tabulated.

### Summary and Conclusions

RORER-143, an antitussive-enzyme combination, composed of d-methorphan, homatropine methylbromide, 1-phenylephrine hydrochloride, pyrilamine maleate and bromelains was evaluated in 50 male patients, all of whom had chronic cough associated with asthmatic bronchitis and pulmonary emphysema.

The experimental design of the study was of the double-blind crossover type. Test drugs employed were d-methorphan, RORER-143, RORER-143 without bromelains, bromelains only, and a placebo control. All patients received three tablets of medication daily for six days. No drug was administered on the seventh day, after which each patient was placed on a crossover medication.

The parameters assessed were: the degree and duration of cough relief; ease of production and viscosity of sputum; wheezing and shortness of breath and patient preference of drug.

RORER-143 was found to effectively control the multiple phases of the cough reflex, to provide up to six hours of continuous relief from the discomfort of cough, and to render the sputum less viscid and make its production easier. Onset of relief occurred in a majority of patients within one-half to two hours after administration, and the side effects observed

(four) were relatively mild and did not constitute any problems to therapy.

A consideration of the difficulties which most patients with some form of obstructive pulmonary disease encounter, makes mandatory experiment with any new antitussive agent or combination thereof. The assessed preparation combines specific ingredients in order to achieve a total therapeutic effect that should be greater than can be achieved with any single antitussive agent alone. Here proteolytic enzymes—bromelains—and other antitussive ingredients are combined. The therapeutic role of the enzyme is of major importance, especially in patients who have excessive production of mucus with frequent development of bronchial casts which occlude the airway and cause great discomfort. The bromelains theoretically help to break down proteinaceous sputum that occludes the airway, making the sputum less viscid; facilitate the absorption of the other antitussive elements; restore the antitussive activity of d-methorphan and help reduce the inflammation and edema so often present. These are decided advantages in the palliative therapy of cough.

RORER-143 deserves a trial where complete antitussive therapy is indicated, as in patients with obstructive pulmonary disease, when more potent agents are contraindicated, and where minimal side effects and long-term use are prime considerations.

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# A Clinicopathological Conference

From The Ohio State University Hospital, Columbus, Ohio

*Edited Under the Auspices of the Ohio Society of Pathologists*

COLIN R. MACPHERSON, M.D., *President*

## PRESENTATION OF CASE

A NEGRO DISHWASHER aged 52 was first admitted to Ohio State University Hospital 18 months prior to his last admission with complaints of epigastric pain, black stools, and syncope. He was found to have a hemoglobin of 3.5 Gm. and guaiac-positive stools. A large ulcer crater in the midportion of the lesser curvature of the stomach was noted on x-ray film. The patient responded well to treatment consisting of blood transfusions, antacids, and anticholinergics. Upper gastrointestinal x-ray done after two weeks of therapy showed almost complete healing of the ulcer crater. During that admission the patient was also noted to have mild congestive heart failure and pulmonary fibrosis.

The patient stated that he had done well until six months prior to his second admission, when he developed again epigastric and left upper quadrant pain relieved with antacids. Two weeks prior to admission he noted increased severity of the epigastric pain. He also noted increasing weakness and increasing shortness of breath during this time. He had no nausea or vomiting. For the three days prior to this admission the epigastric pain became constant and quite severe. In addition, the patient noted tarry stools at this time. On the morning of admission his epigastric pain became worse and he came to the emergency room and was admitted to the hospital. There was no history of chronic ethanol ingestion. The patient smoked cigarettes only occasionally.

## Physical Examination

The patient was well-developed, well-nourished, in moderate distress complaining of abdominal pain. His blood pressure was 130/74, pulse rate 130 per minute and regular, respiratory rate 16/min., and the temperature 98.6°F. The head, eyes, ears, nose and throat were normal. No scleral icterus was noted. The neck was supple and without venous distention or thyroid enlargement. Examination of the chest revealed dullness to percussion in the right base with bilateral fine expiratory rales. Examination of the heart revealed a regular tachycardia; there was no

## Presented by

- N. J. Greenberger, M.D., Columbus, and
  - Emmerich von Haam, M.D., Columbus;
- Edited by Dr. von Haam.

cardiomegaly on percussion; no murmurs or gallops were noted.

The abdomen was flat and soft, the bowel sounds hypoactive. Tenderness to palpation was noted para-umbilically and in the epigastrium; no rebound tenderness was elicited. It was the opinion of several examiners, however, that the tenderness was quite marked and was associated with some involuntary guarding. The liver was palpable 2 to 3 finger-breadths below the right costal margin and was non-tender. The spleen was not palpable. There was no ascites. A right lower quadrant appendectomy scar was noted. Stool from rectal examination was guaiac-negative. There was 1 to 2 plus pitting pedal edema. Neurological examination was within normal limits.

## Laboratory Data

On admission the hemoglobin was 8.2 Gm., hematocrit 33 per cent; there were 7 nucleated red blood cells per 100 white blood cells and marked hypochromia was noted on the smear; the white blood cell count was 14,300 (neutrophils 78 per cent, lymphocytes 18 per cent, monocytes 4 per cent). The urinalysis revealed a normal urine. The CO<sub>2</sub> combining power was 34 mEq./L., sodium 139 mEq./L., potassium 5.2 mEq./L., chloride 103 mEq./L. The total bilirubin was 0.3 mg./100 ml.; the blood urea nitrogen 40 mg. and the creatinine 1.3 mg./100 ml.; the total protein was 6.5 Gm./100 ml. (albumin 3.9, globulin 2.6 grams).

Chest x-ray on admission revealed cardiomegaly with mild congestive changes and obliteration of the right costophrenic angle thought most likely due to organized fluid.



## Hospital Course

On admission the patient was thought to have had a recurrence of his gastric ulcer and antacid therapy was started. He was also thought to be in early congestive failure and treatment with Lanoxin® and Diuril® was begun. The morning following admission he had noted definite improvement in the abdominal pain. Examination at that time revealed less guarding and tenderness in the epigastric area. However, later during the day he developed severe nausea and vomiting which continued on into the evening. He fell on attempting to get out of bed during his second evening in the hospital and was found by the nurse with no blood pressure obtainable, a pulse rate of 132, and respirations 40 per minute. The patient responded to verbal stimuli only by mumbling. No localizing neurological signs were found. His abdomen was markedly distended, and while a nasogastric tube was being passed he suddenly died, 40 hours after admission to the hospital.

## CLINICAL DISCUSSION

DR. GREENBERGER: I might comment that after reading this protocol I think the case could appropriately be termed as one of "sudden death." Before we go into the discussion of this case I wonder if Dr. Dunbar would just briefly discuss the x-rays of this patient?

DR. DUNBAR: His chest film shows cardiac enlargement, mainly left ventricular, and moderate passive pulmonary congestion, which means that this man was in moderate cardiac trouble with some degree of failure. His gastric film shows a distinct ulceration on the mid lesser curvature which appears to be benign. In addition there is rather severe deformity of the distal antrum and duodenum suggestive of multiple recent or old ulcerations in this region.

DR. GREENBERGER: You would agree that he also probably had some basilar emphysema?

DR. DUNBAR: Yes, I'm absolutely sure we would. This will tend to mask the degree of failure, I might add.

DR. GREENBERGER: You say then that this man had evidence of organic heart disease with cardiomegaly, some evidence of chronic pulmonary disease, and peptic ulcer disease with both duodenal and gastric involvement?

DR. DUNBAR: Yes.

DR. GREENBERGER: I would just point out that it's always worth while when assessing a patient with a gastric lesion to do four things: First of all, to gauge his response to therapy—both symptomatically and by x-ray film—as was done in this case; second, to assess his gastric secretory status; third, do cytology; and fourth, consider doing endoscopy.

At this juncture I would like to digress for just

one minute and comment upon the relationship between chronic pulmonary disease and peptic ulcer disease. I think for a long time it has been appreciated that patients with chronic pulmonary disease—primarily obstructive emphysema—have an increased incidence of peptic ulcer, and in a recent study on 105 patients with obstructive emphysema it was found that 24 per cent of them had unequivocal evidence of peptic ulceration. This is a very high incidence figure, which increased to 40 per cent in patients older than 50 years. The mechanism whereby chronic pulmonary disease may lead to peptic ulcer disease is unknown.

Getting back to our patient, we are told that 12 months after his first admission he again had recurrence of pain, shortness of breath, weakness, and tarry stools suggesting that he again had a recurrence of his peptic ulcer disease, probably with gastrointestinal tract bleeding and perhaps with an associated congestive heart failure as well. I would just like to emphasize that the recurrence rate of gastric ulcer is very high; it ranges from 40 to 75 per cent in most series, depending in part on patient selection and how long they were followed. I think the pulse of 130 should have called attention to the fact that this patient probably had a significant blood loss, perhaps in the range of 1000 to 1500 cc., despite a normal blood pressure and despite only a moderately severe reduction in his hemoglobin and hematocrit. He had physical signs consistent with congestive heart failure. I think it should be emphasized that in a patient with congestive heart failure, at this heart rate a murmur might not be detected even if the patient did have a stenotic valve, because the flow past the stenotic valve would be decreased.

We are told that he had tenderness to palpation in the epigastrium and that his stool was guaiac-negative. This is rather bothersome in view of his history of tarry stools and his symptoms suggestive of anemia. How do we explain this? I think there are two possible explanations for it. The first is that he had acute bleeding three days before admission which stopped, or that the guaiac reagent was bad. I think guaiac reagent in student laboratories must be checked repeatedly against known positive material to make sure that the reagent is working properly.

From his laboratory studies we learn that he had a moderately severe anemia with marked hypochromia, which suggests that this patient had been bleeding for more than three days. I think the presence of nucleated red cells in the peripheral smear is consistent with a marrow that has been stimulated to produce red cells in order to compensate for a significant blood loss. I think the slightly increased CO<sub>2</sub> combining power is consistent either with the mild hypercapnia associated with chronic pulmonary disease or mild acidosis associated with congestive heart failure. The blood urea nitrogen of 40 and the low creatinine of 1.3 suggest either that he had blood

in his gut or that he had prerenal azotemia secondary to hypovolemia following blood loss.

On admission it was thought the patient had a recurrence of his gastric ulcer and early congestive failure, and antacid therapy with Lanoxin and Diuril was started. He seemed to be improving and then collapsed while attempting to get out of bed. What are the possible explanations for this syncopal episode? First, we want to consider that he might have had a cerebrovascular accident, either embolism or thrombosis. I think this is much less likely than the latter of the four possibilities I want to mention. Second, he could have had a myocardial infarction with a syncopal episode. Third, he could have had a diminished circulating blood volume and when he tried to stand up he developed severe postural hypotension and fainted.

### Terminal Hemorrhage

The fourth possibility, which I think is the most tantalizing in this patient, is that while he was lying in bed he had a massive gastrointestinal hemorrhage, felt the urge to defecate, attempted to get out of bed, stood up, developed severe hypotension, and collapsed. He was found with no blood pressure and died apparently within a few minutes. I think of note here is the documentation of abdominal distention before he died, which may well be an important clue to this case.

The way I size up this case, I think are three questions that should be answered. First, what was the nature of the underlying heart disease? Second, what was the nature of the intra-abdominal process that precipitated his last admission? Third, what was the cause of his apparently sudden death?

I think the presence of congestive heart failure was well substantiated by the finding of cardiomegaly, pulmonary congestion, hepatomegaly, and peripheral edema. We have no positive evidence for arteriosclerotic heart disease, and there is little evidence that he had hypertensive, rheumatic, syphilitic, or congenital heart disease. I think there is little evidence for any of the rare, unusual causes of congestive failure, such as idiopathic cardiac hypertrophy, hemochromatosis, amyloidosis, scleroderma, myocarditis, adult fibroelastosis. I would conclude then that in spite of the lack of confirmatory evidence on a statistical basis, this man most likely had significant coronary artery disease.

Now I come to the second question, What was the nature of the intra-abdominal process that led to his admission? I think the most likely cause was a recurrent peptic ulcer, probably a gastric ulcer and probably one that was bleeding. The pain he complained of was very similar to the pain which was described previously, and we have laboratory and clinical evidence to suggest that he had sustained significant blood loss that was probably greater than was appreciated. Did he have a recurrent ulcer which was penetrating posteriorly into his pancreas? This

is always a possibility you should think of, but here I would expect the pain pattern to be different with perhaps radiation to the back and perhaps also some tenderness over his lumbar spine. It is possible that he did have a small perforation which was sealed over when a loop or some omentum became adherent to the anterior gastric surface. This could account for the marked epigastric tenderness he had. I think this is a possibility but there is no really good evidence to support this.

### Aneurysm?

Could he have had an abdominal aortic aneurysm which was leaking into his G.I. tract? The pain that he complained of is not inconsistent with this diagnosis, and this could also explain the absence of guaiac-positive stools. However, these people usually have mid to lower abdominal pain which frequently radiates to the loin and the back, and over three-quarters of these patients are found to have calcification in their lumbar aorta visible on x-ray. But most important, about 90 per cent of these people have a pulsatile, expansile abdominal mass, which he did not have, and about 30 to 40 per cent of them have a bruit. So I think the evidence is not very good for a leaking abdominal aortic aneurysm.

He also did not have the classical findings of a dissecting aneurysm, such as chest or back pain, inequality of his pulses, or widening of his thoracic aorta. He had very little to suggest a mesenteric vascular occlusion: He didn't have significant fever or abdominal distention with ileus, bloody diarrhea, an abnormal cardiac rhythm or other conditions which are known to predispose to mesenteric vascular occlusion such as polycythemia vera.

He could have had a myocardial infarction. Patients with myocardial infarction, as you well know, often present just abdominal pain. Furthermore, it could be postulated that in association with myocardial infarction he developed a reactivation of his peptic ulcer disease with bleeding. Some authors have called our attention to the fact that patients who have apparently healed peptic ulcers and subsequently develop myocardial infarction suffer from a greatly increased incidence of activation of peptic ulcer with recurrent gastrointestinal bleeding. However, I don't think that we have any evidence that he had a myocardial infarction although it must be emphasized that no electrocardiogram and no enzyme determinations were obtained.

Also, I don't think he had cholecystitis or a renal calculus, bleeding esophageal varices or gastritis, which I mention only for the sake of completeness. I think therefore that the most likely cause for his abdominal pain was a recurrent gastric ulcer which had been bleeding although it may have stopped at the time he was admitted.

Then we come to the last and perhaps the most important question: What was the cause of his sudden death? Dr. Schoenfield quoted a study in which over



90 per cent of white males dying suddenly and unexpectedly within one hour of apparently natural causes died of coronary artery disease. However, if you examine different subgroups according to race, sex, and the type of death, the percentage due to coronary disease falls to about 60 per cent. So there is a reasonable chance that the immediate cause of death of our patient was something other than coronary artery disease, and it is well known that exsanguinating peptic ulcer or a perforated viscus can lead to shock and sudden death.

### Three Major Possibilities

So now we come down to the three leading possibilities that could have been the cause of sudden death in this patient. The patient could have died a cardiovascular death associated with coronary artery disease, due to hypotension produced by his bleeding gastric ulcer causing myocardial ischemia and fatal arrhythmia. I think that in view of the evidence that he did have heart disease we definitely can't exclude this possibility although I think it is less likely than one of the others that I will mention.

The second possibility is that he perforated a viscus, developed shock and died. The incidence of perforation is considerable in patients with peptic ulcer and ranges between 2 and 12 per cent in various series. It's generally felt that perforation with duodenal ulcer is more common than that with gastric ulcer although this may be because the majority of patients that we see have duodenal ulcer disease. Although this patient could have perforated a peptic ulcer, I think this is a less likely explanation of his death.

The simultaneous occurrence of hemorrhage and perforation is distinctly uncommon and we have good evidence that this patient was bleeding. Furthermore, shock with acute vascular collapse is somewhat unusual with a perforated viscus. Usually if these patients are going to die, they die later—let us say in 24, 36, 48 hours. It is therefore my opinion that this patient exsanguinated from a bleeding ulcer, most likely a gastric ulcer. I would like to point out that exsanguination from a bleeding ulcer is not rare. In one series of 45 cases, 14 died directly as a result of exsanguination with no associated cardiac or systemic disease. Forty-five per cent of the patients had recurrent bleeding rather than continuous bleeding, and I think there is good evidence to suggest that this patient had recurrent rather than continuous bleeding.

My diagnoses on this patient are then as follows: I think he had organic heart disease which on a statistical basis was most likely coronary artery disease; he had chronic pulmonary disease with evidence of emphysema and pulmonary congestion; he had peptic ulcer disease with both duodenal and gastric involvement, and he had a recurrent gastric ulcer which was bleeding. I think the terminal episode was an exsanguinating gastric hemorrhage. I

think the alternative possibility that in association with a bleeding he developed hypotension and myocardial ischemia and died of an arrhythmia cannot be excluded.

### CLINICAL DIAGNOSIS

1. Arteriosclerotic heart disease with mild congestive failure.
2. Pulmonary emphysema.
3. Recurrent peptic ulcer with fatal hemorrhage.

### PATHOLOGIC DIAGNOSIS

1. Multiple chronic gastric ulcers with gastrointestinal hemorrhage and perforation.
2. Diffuse peritonitis.
3. Centrolobular pulmonary emphysema.
4. Cor pulmonale.

### DISCUSSION OF PATHOLOGY

DR. VON HAAM: Upon opening the distended abdomen a large amount of yellowish green fluid poured out and a noticeable amount of gas escaped which had a very foul odor. The peritoneum was markedly injected and covered with thick fibrinous exudate. The heart showed increased thickness of the right ventricular wall and dilatation of the right ventricle. There was only moderate arteriosclerosis of the coronary arteries. Both lungs showed a moderate diffuse fibrosis and numerous emphysematous blebs predominantly in both upper lobes. Both pulmonary arteries showed arteriosclerotic plaques. The lower lobe of the left lung showed a recent consolidation.

The liver surface was covered with yellowish green exudate. The organ itself appeared congested. The stomach was distended and contained a small amount of greenish black material. Three distinct ulcers could be recognized on the lesser curvature, one of which had a hemorrhagic base, another showed a 1 cm. perforation, and the third was indurated and extended into the pancreas. The small intestine contained a moderate amount of reddish green material, while the large intestine contained brownish gray and green feces. The remaining organs were not remarkable.

*Microscopically*, we found moderate myocardial fibrosis with marked hypertrophy of the muscle of the right ventricle. The pulmonary vessels appeared thickened and there was definite histologic evidence of centrolobular emphysema. The bronchi were filled with cells and secretion. There was no evidence of bronchial asthma. Microscopic sections through the kidneys showed glomerular ischemia. The bone marrow showed definitely an increase in erythropoiesis. Histologic examination of the stomach revealed severe hypertrophic gastritis with subacute peptic ulcers.

From this we felt that the patient suffered from three gastric ulcers, one of which had obviously been bleeding, another had perforated, while the third one was walled off by the pancreas. No exsanguinating hemorrhage could be recognized. The astonishing finding was the diffuse peritonitis which was

apparently the cause of death and which was not recognized while the patient was still alive. The changes in the kidneys and the lungs are ample evidence that the patient suffered a fatal shock. His heart condition was that of a failing cor pulmonale without evidence of myocardial disease.

DR. GREENBERGER: I think in retrospect that

there are several clues to suggest that the cause of his death was probably perforation rather than exsanguination. The tremendous nausea and vomiting that he had throughout the second hospital day and the marked distention of his abdomen that made them attempt to pass a nasogastric tube should put us on the right track.

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**ALCOHOLIC HEART DISEASE.**—Fifty patients with evidence of myocardial disease and a long-standing high consumption of alcohol were seen over a ten-year period. The usual causes of myocardial disease were excluded as far as possible. All but one were male, and their ages ranged from the fourth to eighth decades. Three clinical syndromes which depend on the dominant derangement of circulatory function at any one time were recognized.

Cardiac beriberi (aneurin-responsive disease) was the least frequent and least serious disorder. It occurred in five heavy beer-drinkers (not averse to spirits as well) and two of these had had a previous gastrectomy, which was thought to provide an additional adverse nutritional factor. Therapeutic response to aneurin and withdrawal of alcohol was good in these patients, but relapse has occurred following resumption of previous habits in at least one, and another has cardiographic evidence of persistent myocardial abnormality.

A second, larger, group of patients presented with arrhythmia—especially atrial fibrillation—with or without varying degrees of heart failure. The ventricular rate tended to be fast and multifocal ventricular ectopics were common. Spontaneous return to sinus rhythm occurred in some, but usually relapse followed after a variable period. Fast heart rates, frequent extrasystoles, cardiomegaly, and abnormal QRST complexes on the cardiogram distinguished the condition from so-called idiopathic atrial fibrillation. Treatment with digitalis, diuretics, and conversion of rhythm met with variable success in this group. Reasonable health has been maintained in some when total abstinence has been observed and when the disease process was not far advanced on first presentation. The development of an arrhythmia with accompanying palpitation may draw attention to alcoholic heart disease before irreversible damage has been done.

A third group of patients presented with hypokinetic heart failure, cardiomegaly, and electrocardiographic evidence of severe myocardial disease. Response to treatment was moderate at first but an episodic downhill course was usual.

The electrocardiogram showed a wide range of abnormality as in other forms of cardiomyopathy. There was a fairly close correlation between the degree of cardiographic abnormality and the severity of the myocardial disease as judged by heart size and response to treatment. Mild polycythemia was observed in many patients, and was thought to be a response to low-grade chronic cardiac insufficiency. Serum cholesterol levels tended to be lower than average and were believed to be the result of dietary replacement by ethanol.

Diagnostic problems abound in these patients, especially when the story of alcoholism is missed or its significance overlooked. In our experience most of these men consumed far more than was admitted in the initial interrogation. "Fallen hypertension" and silent coronary occlusion were common diagnostic errors (there was no occlusive coronary disease in nine cases examined at necropsy). Atrial fibrillation, a fast ventricular rate, sweating, and tremor with a low serum cholesterol combined to produce a superficial resemblance to thyrotoxicosis. As in other forms of cardiomyopathy, constrictive pericarditis has been erroneously diagnosed in patients with severe heart failure, but attention to clinical detail and the electrocardiogram should indicate the correct diagnosis and prevent unwarranted surgery. —Wallace Brigden, M. D., and John Robinson, M. B., London, England: *British Medical Journal*, Vol. 2, 1283-1289, November 21, 1964.



# Maternal Mortality Report For Ohio - 1962\*

By the OSMA COMMITTEE ON MATERNAL HEALTH

WITH a sense of pride, your Committee on Maternal Health presents its eighth annual report. This document is published in compliance with a House of Delegates directive adopted April 23, 1953, creating the Committee on Maternal Health, and follow-up action taken by The Council on January 16, 1954.<sup>1</sup>

The report consists of five sections, the first briefly summarizing activities of the Committee since its last report to The Council on September 20, 1964.<sup>2</sup> In the second part, various projects sponsored by the Committee are described. A statistical summary of The Ohio Maternal Mortality Study\* for 1962 is presented in the third portion. The survey covers all of Ohio's 88 counties, and includes data on patients who died outside of hospitals, as well as those who were hospitalized. In the fourth section, statistics are analyzed briefly indicating current trends in maternal deaths; the last part contains recommendations presented by the Committee based upon experience gained from the Maternal Mortality Study.

## Activities

Twenty members comprise the Committee on Maternal Health. They represent the 11 Councilor Districts of Ohio, and from the profession, they furnish an excellent cross-section of general practice as well as the specialties, viz., obstetrics, gynecology, cardiology, pathology and anesthesiology. One new member was appointed to the Committee during the past year, to replace a member who died suddenly. In the previous 12 months the Committee held four regular meetings. In addition to investigation and action on matters pertaining to maternal health in Ohio, members studied, evaluated and classified 184 maternal mortality cases using "Guiding Principles for Obstetric Care" to assess avoidability in every case.<sup>3</sup>

Quarterly, in this column "Maternal Health in Ohio," the Committee published in *The Journal* se-

lected case reports from the Maternal Mortality Study, on an anonymous basis.<sup>4</sup> Each report was followed by instructive comments of the Committee; every article carried final pertinent comments of an anonymous consultant, a specialist in his field.

The Committee maintains close liaison with well established *County* maternal mortality studies operating on an *annual basis* in Cleveland, Columbus, Cincinnati, Dayton and Toledo. Collateral support is constant and mutual, aimed at the establishment of complete and accurate details for the study of every maternal death case throughout Ohio.

Queries have been received relative to the cost of the Ohio Maternal Mortality Study. An exact calculation of cost is difficult due to various Committee functions. The annual budget prescribed for the Committee is \$1500. Expenditures for the Committee during 1964 were listed officially as \$1,754.94.

## Projects

For the eight-year period (1955-1962), 967 maternal cases in the Committee files have been coded on IBM cards. This intricate system for data processing has made readily available a wealth of material covering maternal deaths in Ohio, for information and educational programs.

Under the direction of a subcommittee, an exhibit "Toxemias, A Primary Cause of Maternal Death" was prepared for the Committee. The display, presented during the Annual Meeting of the Ohio State Medical Association, May 9-14, 1965, depicted prevailing trends derived from experience in the Ohio Maternal Mortality Study during the seven-year period (1955-1961).

Still another subcommittee pursued its project to crystallize the interpretation of a "prescribed course" for registered nurses trained to administer anesthesia to obstetric patients, (Sec. 4731.35 of Ohio Revised Code). Interim progress, details of exploration and the final recommendations completing work of the subcommittee were published in *The Ohio State Medical Journal*, June, 1965.<sup>4</sup>

A third subcommittee, having completed exploration, study and recommendations on a project involving the admission of "clean gynecologic cases" to maternity units of Ohio Hospitals (Regulation 78 A,

\*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the State. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

Ohio Sanitary Code, revised), awaits further instructions. Presently the recommended program is in the hands of the Ohio Director of Health.

By invitation, various members of the Committee continue to meet with various county medical societies, and local specialty groups throughout Ohio. This important facet in the education and information program supporting "Maternal Health in Ohio" has enjoyed popularity through support and stimulus of The Council. Currently the Committee is engaged in studying possibilities of implementing a "Rubella Control Program" proposed to investigate the presence of rubella antibodies in Ohio women *before* they become pregnant.

Statistics from the Ohio Study for the year 1962 are published below, in compliance with directives of The Council. Terminology and nomenclature used throughout the study were adopted after careful deliberation. They follow closely those employed in the International Classification, for purposes of uniformity.

#### Ohio Maternal Mortality Study Statistics for 1962

Total Live Births in Ohio, 1962	217,465
(Total Cases in files, 8 years, 1955-1962...969)	
Total Cases Studied (1962)	99
Cases not studied due to lack of information	8
Undetermined	0
<b>Maternal Deaths (Classified)</b>	<b>66</b>
Non-white	22
White	44
<b>Age:</b>	
Teens	1
20's	31
30's	26
40's	8
<b>Parity:</b>	
Primigravidae	13
Multiparae	48
Unknown	5
<b>Place of Death:</b>	
Hospital	57
Home	5
Other	4
<b>Type of Delivery:</b>	
Not Recorded	2
Operative	34
Nonoperative (spontaneous)	12
Not delivered	18
<b>Route of Delivery:</b>	
Not recorded	0
Vaginal	41
Cesarean	7
(antemortem)	7
(postmortem)	0
Laparotomy (ectopic preg.)	0
Not delivered	18
<b>Case Classification: (when death occurred)</b>	
Group I (fr. concept. to 20th wk.)	7
Group II (fr. 20th wk. to 28th wk.)	4
Group III (fr. 28th wk. through term)	10
Group IV (postabortal, postpartum)	45
<b>Autopsies</b>	<b>53</b>
(includes 18 coroners' cases)	
<b>Prenatal Care (apparent from data sheets)</b>	
None	11
Unknown or not reported	5
Adequate	29
Inadequate	14
Excluded (ectopic preg. and abortion)	7
<b>Classification of Preventability:</b>	
Nonpreventable	21
Preventable (avoidable factor)	45
Patient responsibility (P <sub>1</sub> )	17
Personnel responsibility (P <sub>2</sub> )	17
Both P <sub>1</sub> and P <sub>2</sub>	11
P <sub>3</sub>	0
<b>Classification of Primary Causes of Death:</b>	
Hemorrhage	21
Abortion, without sepsis	0

Abruptio	1
Afibrinogenemia	4
Abruptio	3
Am. fl. embolus	1
Dead fetus	0
Ruptured uterus	0
Atony, uterine, postpartum	2
Ectopic pregnancy (without sepsis)	4
Laceration, extrauterine	0
Placenta Praevia	0
Retained Placenta	0
Ruptured uterus (no afibrin.)	8
Other	2
<b>Infection</b>	<b>17</b>
Abortion, alleged "criminal"	9
Abortion, septic, spontaneous	1
Pyelitis, Pyelonephritis	1
Up. Resp. Inf.	1
Other:	
Peritonitis	0
Septicemia (puerperal sepsis)	2
Septicemia (other)	3
<b>Toxemia</b>	<b>8</b>
Acute yellow atrophy	0
Hypertension, chronic (incl. hypertension with cerebrovascular hem.)	2
Eclampsia	5
Preeclampsia	0
Puerperal Toxemia, not specified	1
<b>Other</b>	<b>20</b>
Amniotic fl. emb. (no hem.)	3
Anesthesia	3
(general)	2
(regional)	1
Cardiac disease	6
Cerebrovascular hemorrhage (no tox.)	2
Pulmonary embolus	5
Renal disease, chronic, unspecified	1
All other	0

In Ohio, there were 217,465 live births reported during 1962. From this maternal mortality study, the Committee classified 66 *maternal* deaths for the year. The maternal mortality rate was 0.30 per 1,000 live births, or 3.03 per 10,000 live births for 1962.

#### Discussion

In a matter of comparison, the statistics listed above (for 1962) are more significant since there were 12,243 fewer live births reported in Ohio in 1962 than in 1961; 12,754 fewer live births in 1962 than in 1960; 15,113 fewer live births in 1962 than in 1959.

Every case was studied carefully in the usual manner by the Committee. All *available* facts were evaluated on an anonymous basis after which each case was classified as to preventability, listing avoidable factors. Patients who had received *less* than "Ideal Care"<sup>3</sup> were classified as preventable maternal deaths. Again, members were cognizant that a certain number of cases escaped inclusion in the 1962 Study, perhaps through an omission of the contributing cause of death on the official certificate, or a failure of the attending physician to list "pregnancy" as a contributing cause.

Out of 91 cases studied for 1962, 66 (72.5 per cent) were voted *maternal* deaths, while 25 were voted *nonmaternal deaths* (no connection with the pregnant or puerperal state); no case had the cause of death undetermined. Eight cases are still "out" pending a receipt of more complete information. Again, the great majority of deaths fell in the 20 and 30 year age groups. Multiparae led the parity classification by a huge comparative number; and 57 of the 66 patients died in hospitals while only five



died at home. Four patients were "D. O. A." in emergency rooms.

Of the 66 maternal deaths, 18 died *undelivered*, 34 had operative deliveries, 12 had nonoperative (spontaneous) deliveries and the remaining two failed to have the delivery *type* recorded. Forty-one cases recorded vaginal deliveries, while seven others died after cesarean section. There were *no* deaths associated with laparotomy for ectopic pregnancy nor were there any postmortem cesarean sections in this series. Curiously enough, 45 of the 66 patients (68.1 per cent) died postabortal or in the postpartum state.

Autopsies were performed in 53 of the cases (80.3 per cent); 18 of the autopsies were done by the coroner.

Of the 66 maternal deaths only 43.9 per cent of the eligible group apparently had received *adequate* prenatal care; seven cases were excluded (ectopic pregnancy and abortion) while five were not recorded. Forty-five of the 66 cases were voted *preventable* maternal deaths; of the forty-five, 17 were assessed *patient* responsibility.

A survey of the primary cause of maternal death in the 66 cases (Fig. 1) provides interesting fea-

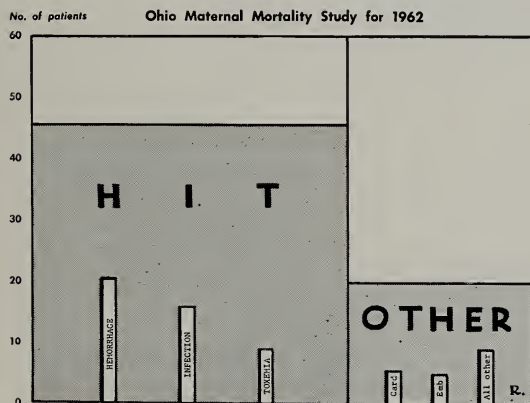


Fig. 1. Classification of primary causes of death, 66 maternal deaths for 1962

tures: Hemorrhage (from major and subordinate causes) again *leads* the list as a single primary cause of death, with 21 cases (31.8 per cent); this figure again includes *eight* cases with *ruptured uterus*! The picture is similar to the scarlet trend published for the year 1959.<sup>5</sup> Two cases listed under "Other Causes of Hemorrhage" provide an unusual contributory cause; Case No. 793 sustained a "ruptured peritubal vessel," and Case No. 866 developed a "ruptured ovarian vein." Both patients died of uncontrollable hemorrhage.

Over half of the 17 deaths due to sepsis in 1962 were associated with criminal abortion! Toxemia was responsible for eight maternal deaths in 1962, compared to only two in 1961; five of the eight died from eclampsia. Among "Other Causes," cardiac disease (six cases) and pulmonary embolus (five

cases) hold the questionable distinction of leading all of the 20 "other causes." This trend has been prevalent, more or less, throughout the past six or seven years.

### Recommendations

1. The Committee recommends continuation of the Ohio Maternal Mortality Study, with all of its research and education facets, in order to reduce further maternal mortality and morbidity throughout Ohio. Maternal death trends can be controlled by education focused upon prevailing etiologic factors.

2. The Committee recommends that steps be taken to encourage local and county societies to appoint the Chairman of the (local) Committee on Maternal Health for a term of two or three years, instead of only one. Currently the custom of a chairman acting for one year terminates his position just as he becomes accustomed to his functions in the local study.

3. It is recommended that local committees establish closer liaison with local Health Departments and Vital Statistics Offices, in order to obtain information concerning potential maternal cases currently being omitted from the Study. This refers particularly to patients who deliver in a hospital and die later at home. All cases should be included.

4. Support of Committee activities and the Ohio Study by members of The Council is acknowledged and appreciated. Program chairmen of county societies are invited to request Committee members to participate in local programs presenting problems pertinent to "Maternal Health in Ohio." Correspondence may be addressed to The Committee on Maternal Health, OSMA Headquarters Office, 79 East State Street, Columbus, Ohio 43215.

The Chairman, with sincere appreciation, acknowledges the loyal support of the Committee members who performed their duties conscientiously during the past year. On behalf of the Committee, the Chairman gratefully acknowledges assistance afforded by Council, attending physicians, representatives of various county medical societies, the Ohio Department of Health and numerous other agencies and individuals. Without their efforts and untiring cooperation this Maternal Mortality Study could not have been completed.

Respectfully submitted,

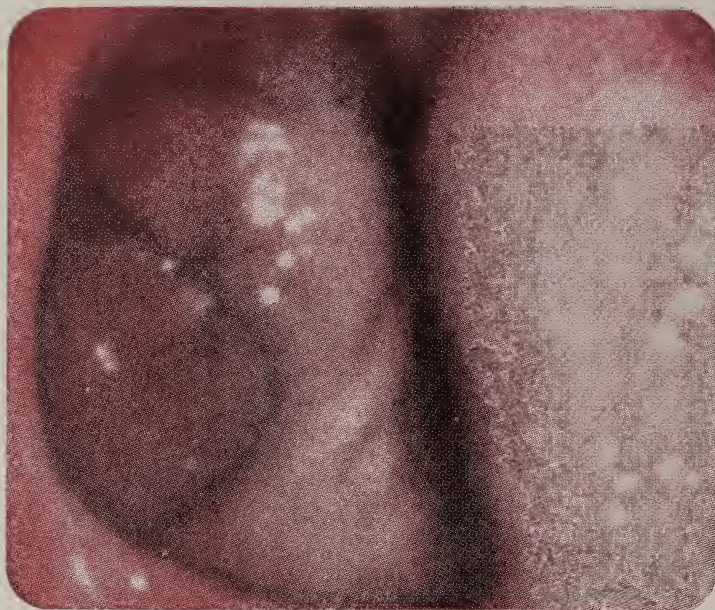
ANTHONY RUPPERSBERG, JR., M. D., *Chairman, Committee on Maternal Health*

Approved by The Council of the Ohio State Medical Association, September 19, 1965.

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5. Committee on Maternal Health: Maternal Mortality Report for Ohio — 1959. *Ohio State M. J.*, 58:1386-1388 (December) 1962.

## Intragastric photography studies<sup>1</sup>



**A/** E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

**B/** Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.





# Now you can see Pro-Banthine® at work (propantheline bromide)

Pro-Banthine is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastrosopic studies<sup>2</sup> have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthine. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superior-

ity of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Dosage**—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

**Side Effects and Contraindications**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

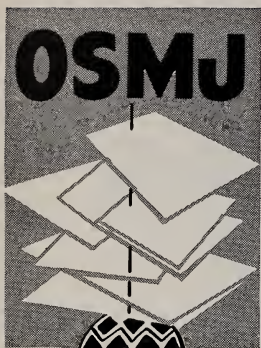
Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

**SEARLE**

*Research in the Service of Medicine*



# NEWS AND *Organization Section*

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## Annual Roundup on Federal, State and Local Taxes for Physicians

**T**HIS year many physicians in private practice will pay Social Security taxes as self-employed persons for the first time. Action taken by Congress adds one more category to the list of returns that must be filed and taxes paid under Federal, State and local laws. This article is presented to furnish at least basic information on the several tax structures, deadlines, forms to be filed and liability of the taxpayers.

Only brief and general data can be given in an article of this kind. For more specific information on individual tax liability, the reader should consult an authentic tax manual, seek the advice of an authorized tax expert, or present his questions to personnel of respective taxing agencies. A tax expert can point the way to many savings under the law as well as guide the taxpayer away from embarrassing errors.

The following tax categories are discussed in this article under respective headings:

(1) The Federal Social Security program, including new liability of physicians as self-employed persons, withholdings from employees' wages, etc.

(2) Federal Income Tax, including payroll deductions.

(3) Ohio Personal Property Tax, including the tax on tangible property used in business and the tax on intangible personal property such as stocks, bonds, investments, cash and accounts receivable.

(4) Ohio Workmen's Compensation tax, required of those with three or more employees (optional for

those with one or two), and the Disabled Workmen's Relief Fund tax.

(5) Ohio Sales and Use Tax.

(6) Ohio and Federal Unemployment Insurance Taxes.

(7) Municipal Payroll Tax, applying to residents of cities or villages which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

### SOCIAL SECURITY TAXES

On July 30, 1965, the President signed the Social Security Amendments of 1965, putting into effect Public Law 89-97.

Doctors of medicine, as self-employed persons, are now included under the Old-Age, Survivors and Disability program of Social Security effective for the taxable years "ending on and after December 31, 1965." This means that the self-employed physician must pay 5.4 per cent of the first \$4800 of net earnings for 1965. This tax is to be reported on Schedule SE of the income tax return and must be paid on or before April 15, 1966, or at the time the final income tax forms are filed.

For the calendar year 1966, the rate will be 6.15



per cent and this amount will apply on the first \$6600 of net income. This includes a tax of 0.35 per cent on net profit up to \$6600 applicable to the new hospital insurance program. Beginning in 1966 the tax may be paid quarterly with your Declaration of Estimated tax (Form 1040ES).

The physician who has not had a social security number assigned may use his taxpayer's identification number, which automatically becomes the social security number. This is not to be confused with the Employer's Identification Number.

The physician who has a part-time salaried position through which social security taxes are withheld need not pay the self-employment tax if social security taxes are withheld on income up to \$6600 (\$4800 for 1965). If the salary subject to withholdings is less than \$6600 (\$4800 for 1965), he must pay self-employment tax on the difference between the maximum and his salary.

Interns and residents come under compulsory coverage effective January 1, 1966 on the same basis as other salaried employees.

The physician who pays his first social security tax for 1965 begins to accumulate credit under the Old Age, Survivors and Disability program as of January 1, 1965. Interns and residents who come under coverage for the first time on January 1, 1966, begin to accumulate credit at that date, except for previous non-professional employment.

### Health Insurance Programs

All persons aged 65 or over, or who will reach age 65 before 1968, are eligible for benefits under the hospital insurance program, with the exception of certain federal employees and certain aliens. Persons receiving social security benefits automatically become eligible when the program goes into effect on July 1, 1966. Services in extended-care facilities become available January 1, 1967.

Persons who are not now receiving social security benefits and who will be aged 65 by December 31, 1965, should apply for benefits under the hospital insurance program by March 31, 1966. Persons who reach age 65 on or after January 1, 1966 and who are not receiving benefits should apply 3 months before their 65th birthday.

All persons aged 65 and over are eligible for benefits under the medical program when it becomes effective July 1, 1966, if they enroll by March 31, 1966 and agree to pay \$3 a month beginning July 1, 1966.

For persons aged 65 before January 1, 1966, an enrollment period is now in effect and will continue through March 31, 1966. Persons attaining age 65 after December 31, 1965, will have enrollment periods of seven months beginning three months before they attain age 65. In the future, general enrollment periods will be from October 1 to December 31, in each odd year, beginning in 1967. No person may

enroll more than three years after the close of the first enrollment period in which he could have enrolled.

Benefits under the medical program are for the individual enrollee only. The spouse who is aged 65 must enroll also if benefits are desired for both husband and wife.

### Social Security for Employees

As employees, physicians will be interested in the following provisions of the law:

Every employer of one or more employees is required by law to deduct social security taxes from the employee's wages and to contribute a matching amount himself. Through December 31, 1965, the amount of deduction is 3-5/8 per cent of the employee's wages up to \$4800, and an equal contribution from the employer.

Beginning January 1, 1966, the rate will be 3.85 per cent each for employee and employer, with deductions made on the first \$6600 of wages. In addition, a deduction of 0.35 per cent must be made from the first \$6600 of the employee's wages and a similar amount paid by the employer for the new health insurance program.

The tax return and informational return combined in one report is to be filed quarterly during the month after the quarter ends.

### Employees Receiving Benefits

For the benefit of physicians who employ persons now receiving social security benefits, the following information is presented:

A worker under age 72 who is receiving benefits under the social security program will not lose any payments unless he makes more than \$1500 in a year. If he makes more than that amount certain deductions apply to his benefits. A person over age 72 may earn any amount and not lose benefits.

Both men and women may elect to receive benefits after age 62 at somewhat reduced rates. The widow of an insured worker may elect to receive benefits after age 60 at reduced rates.

Under the new law, a disabled worker whose disability is expected to last for at least 12 months may qualify for disability benefits beginning with the seventh month of disability. The new law also liberalizes the requirements affecting people who are disabled by blindness.

Benefits to a child who is eligible to receive such benefits now continues though age 21, if the child is a full-time student in an accredited school. If the child is not a full-time student, benefits continue to the 18th birthday.

Not covered for social security purposes is work done by a child under 21 for his parent, by a husband for his wife, or by a wife for her husband. This applies also to foster or step-relationships. Services performed by or for "in-laws" and relatives other

than those named are covered, provided a genuine employment relationship exists.

Under current provisions, work that a parent does for a son or daughter in the course of a trade or business is covered by Social Security. However, work done in the household of a son or daughter is not covered.

Domestic workers in private homes who receive wages of at least \$50 in a quarter are covered. In other words, if a taxpayer has a cleaning woman, or other domestic worker, only one day a week, she must be covered if she earns \$50 or more in a quarter (approximately \$3.85 per week). Domestic workers in farm homes come under the same provisions as farm workers.

A farm worker who earns \$150 in cash wages during the year must be covered. However, farm workers who perform agricultural services for an employer on 20 or more days during a calendar year for cash at a rate based on some unit of time must be covered regardless of the rate.

Only cash is considered in wages paid to domestic or farm workers, not wages in kind.

### FEDERAL INCOME TAX

Federal Income Tax returns for 1965 will be filed and payments made under provisions of the Revenue Code of 1954, subject to revisions under the Revenue Act of 1962, the Revenue Act of 1964, and certain Treasury Department regulations issued under authority of those provisions.

Substantial savings for the taxpayers were incorporated into the Revenue Act of 1964, and part of these savings were fully effective for the taxable years beginning in 1965. Taxpayers who use the previous year's return as a basic guide, should take these changes into account.

#### Social Security Number

Doctors of medicine are now included under the Social Security program. The social security number required on tax forms is the same as the account number used on previous income tax returns.

#### Who Must File

Every citizen or resident of the United States must file an income tax return if the gross income for the year was \$600 or more for the person under age 65, or \$1200 for the person age 65 or over.

#### Forms and Payments

There are two types of returns, Form 1040A, and Form 1040.

Form 1040A may be used if the income was less than \$10,000 and consisted entirely of wages reported on Withholding Statements for such wages and not more than \$200 total of other wages, interest and dividends (excluding \$100 of dividends). When this form is used, if the income was under \$5,000,

the Internal Revenue Service will figure the tax and send the taxpayer a bill or refund. If the income was between \$5,000 and \$10,000 the taxpayer must compute his own tax.

Form 1040 is used if the income is less than \$10,000 and the taxpayer must include income from sources not eligible for reporting on Form 1040A; wishes to deduct from wages certain reimbursed expenses, travel, transportation, etc.; or the taxpayer wishes to deduct credits for dividends and retirement income.

Form 1040 must be used if the income was \$10,000 or more. Separate schedules, in addition to Form 1040, are provided for reporting business and professional income, capital transactions and other income. They are Schedules C, D and B.

Form 2106 may be used to support travel and transportation expenses.

### Declaration of Estimated Tax

Virtually all physicians in practice private, and other persons who have income from sources other than wages subject to withholdings, are required to file declarations of estimated income tax, and to make periodic payments on estimated tax.

Specifically, every citizen or resident of the U.S. is required to make a declaration if his total estimated tax exceeds his withholdings (if any) by \$40 or more; and

(a) He can reasonably expect gross income exceeding—

(1) \$10,000 for a head of a household or a widow or widower entitled to the special tax rates;

(2) \$5,000 for other single individuals;

(3) \$5,000 for a married individual not entitled to file a joint declaration;

(4) \$5,000 for a married individual entitled to file a joint declaration, and the combined income of both husband and wife can reasonably be expected to exceed \$10,000; or

(b) He can reasonably expect to receive more than \$200 from sources other than wages subject to withholdings.

A single declaration may be made on Form 1040-ES on or before April 15, 1966, for the 1966 taxable year; or, quarterly declarations may be made on or before April 15, June 15, September 15, 1966, and January 15, 1967.

The estimated tax may be paid in full with the declaration on or before April 15, or quarterly on the dates indicated above. No penalty is imposed if the estimated tax is not less than 70 per cent of the actual tax liability, and installments are paid on time. Amended declarations should be filed if the estimated income changes substantially.

Husband and wife may file separate declarations





**the sedentary life  
is often the seat of  
low back pain**

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

*The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ to relieve pain ☐ to relax muscles ☐ to restore mobility.*

*Indications:* 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

*Contraindications:* Allergic or idiosyncratic reactions to carisoprodol.

*Precautions:* 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

*Side Effects:* The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

*Dosage:* Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

*Supplied:* Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

*Before prescribing, consult package circular.*

**for the relief  
of low back  
sprains and strains**

**SOMA<sup>®</sup>**  
**(CARISOPRODOL)**



Wallace Laboratories, Cranbury, N.J.  
269013

and a joint final return, or may file a joint declaration and separate final returns.

### Income-Splitting

Most married physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of household" may claim about one-half the tax benefit afforded a married couple on a joint return.

An unmarried widow or widower who maintains a home for his dependent children is allowed to use joint return rates in the two years following death of a spouse.

### Adjusted Gross Income

For the person on salary, the total salary plus amounts received from interest, dividends, rent or from other sources constitutes the gross adjusted income.

The physician in private practice arrives at his adjusted gross income by deducting from cash receipts (or from total charges if he uses accrual method of reporting income) all items of expenditure necessary in earning his income. The more important items are described in the following sections.

### Deductible Business Expenses

**Office Rent** — Rent paid to another person for office space may be deducted. That portion of rent paid for the office in a combined office-home may be deducted on a pro-rata basis of space used. If the physician owns his own home-office combination, he may not deduct rent, but may claim depreciation on that portion used as an office, again on a pro-rata basis.

**Automobile** — Cost of repair and upkeep of an automobile, including gasoline, service, etc., used in professional visits may be deducted. Salary of a chauffeur, sums paid for taxi or other transportation fare, for professional purposes may be deducted.

Depreciation may be deducted on an automobile used in professional business. Annual depreciation may be deducted on the basis of cost, less trade-in value, divided by the number of years the taxpayer uses the vehicle. The physician should seek the advice of a tax expert as to whether the "declining-balance method" of depreciation would be advantageous to him.

If an automobile is used both for professional and family purposes, a proportion of depreciation, cost of upkeep, etc., may be deducted, based primarily on mileage.

Damage to an automobile used in professional work, not done through negligence, and not covered by insurance, is a deductible item.

**Professional Dues and Publications** — Dues paid to professional associations to which the physician belongs, in the interest of his profession, are deduc-

tible. Publications purchased in the interest of his professional work become deductible items, as do publications purchased for the waiting room.

**Refresher Courses** — The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Section 1.162-5 of the IRS regulations).

Deductions may be made for "refresher" type courses, or those attended to maintain the skills of the physician and to keep him abreast of developments in his field of practice. Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

**Travel Expenses** — The Revenue Act of 1962 deals extensively with travel expenses. Emphasis is placed on the distinction between travel time and expenses devoted to business or professional purposes and that used for vacation or entertainment. Regulations are less restrictive for the taxpayer if the trip does not exceed a week or if personal or vacation time does not exceed 25 per cent of the total time of the trip. Expenses for personal activities such as sightseeing, social visiting, personal entertaining or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone.

**Entertainment Expenses** — Section 4 of the Revenue Act of 1962, or Public Law 87-834, added new rules of proof and degree of business relationship for the Federal income tax treatment of certain business travel, gift and entertainment expenses.

In general, a physician may deduct on his Federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service by appropriate evidence that such expenses are ordinary and necessary business expenses and clearly related to the production of business or professional income.

Exact records on each item are important. Here are criteria that may be used to determine the deductibility of entertainment expenses:

Specific purpose of entertainment; nature of the doctor's practice; period of time in practice; number of patients he already has; percentage of patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from doctors entertained and any indication of the effect of the entertainment on these referrals; number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive; whether or not other doctors in the same type of practice in the locality have entertainment expenses.

**Depreciation** — Important principles in regard to claiming depreciation are contained in Treasury De-



partment Publication No. 456, entitled *Depreciation, Guidelines and Rules*, revised August, 1964.

Depreciation may be claimed on virtually all equipment and furnishings of more or less permanent value used in practice; also on buildings used for business or professional purposes.

If the taxpayer is unfamiliar with methods of claiming depreciation, he may wish to consult a tax expert as to which method would be to his advantage — straight - line, declining - balance, double declining - balance, or sum - of - the - digits method.

**Insurance Premiums** — Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Premiums paid for disability insurance are deductible only if the policy specifies that benefits are for business or overhead expenses.

**Other Business Expenses** — Salaries of all persons whose duties are connected with professional work, and the employer's share on Social Security and other payments made in behalf of employees; items consumed-in-the-using such as medicines, bandages, laboratory supplies, etc.; uniforms or other garments used in professional work but not suitable for street wear; cost of telephones, telegrams, heat, light, water, etc.; Ohio and Federal gasoline tax, if this has not been included in cost of gasoline; interest on business indebtedness; cost of replacement or repair of professional equipment lost or damaged by fire, theft, etc., not covered by insurance; certain legal expenses, etc.

### Exemptions and Allowances

An exemption of \$600 may be claimed by the taxpayer for himself. He may also claim an exemption of \$600 for each dependent of close relationship, or for certain other dependents living in his household. To claim an exemption for a dependent, the taxpayer must have furnished over half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than \$600 for the year. A child may earn \$600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of \$600 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and

still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

### Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, providing that there is not a duplication of deductions under the two categories.

**Medical, Dental and Drug Expenses** — Taxpayers will claim medical, dental and drug expense deductions for 1965 under existing regulations. (Changes in regard to these deductions brought about by Public Law 89-97 are effective for taxable years beginning January 1, 1967; not for the current or coming year.)

Deductible items under these headings include the cost of diagnosis, cure, mitigation, treatment or prevention of disease, or any treatment that affects a part or function of the body; also costs of transportation primarily for or essential to medical care and cost of travel prescribed for the relief of specific ailments. Included within the percentage deductions for this year are costs of medical and hospital insurance.

The following provisions and limitations apply to deductions for medical expenses:

The taxpayer under 65 may deduct medical, dental and drug expenses which exceed 3 per cent of adjusted gross income, except only that amount paid for drugs that exceeds 1 per cent of adjusted gross income may be deducted.

The percentage limitation does not apply to medical and drug expenses for spouse or for dependent parents who are 65 years old or over.

The taxpayer over 65 may also disregard the percentage limitations on medical, dental and drug deductions.

The deduction may not exceed \$5,000 multiplied by the number of exemptions claimed, with these further provisions: That no more than \$10,000 be deducted on a separate return; and no more than \$20,000 on a joint return, or a return filed by a surviving spouse or a head of a household. Larger limits apply to disabled persons aged 65 or over.

Deductions may not be claimed for medical items reimbursed by insurance.

**Contributions, Gifts, etc.** — Deductions up to 30 per cent may be claimed for contributions for religious, charitable, scientific, literary, educational and similar purposes, including contributions to governmental agencies through which the gift is made for public purposes. Travel in behalf of volunteer charitable work is deductible at five cents a mile.

Under certain provisions, gifts above the 30 per cent ceiling may be carried over for as much as a five-year period.

Donations to private foundations remain under the 20 per cent ceiling, with certain exceptions. Still not eligible for deductions are gifts to candidates for

public office, political parties, organizations seeking to benefit a particular group, organizations where there is a profit motive, subversive groups, organizations which attempt to influence legislation or engage in propaganda, etc. Gifts to fraternal or professional organizations are eligible for deductions only when the contribution goes to a special group set up within the organization for charitable, educational or other approved purposes.

**Interest** — The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

**Taxes** — Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, state gasoline taxes.

The following state and local taxes may not be deducted: Auto plate and driver license fees, cigarette and tobacco taxes, alcoholic beverage taxes, admission, occupancy and transfer taxes.

**Casualty Losses and Thefts** — The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, provided the amount is in excess of \$100 for each loss and provided the amount is not claimed as a business deduction and not covered by insurance.

#### Retirement Income

Pensions and annuity payments received by individuals fall into three classes for federal income tax purposes: Nontaxable, fully taxable, or partly taxable. Certain items of retirement income also may be subject to credit, allowances varying according to whether the retired person is under age 65, over that age, or over age 72. A person who is receiving retirement income, therefore, would do well to check with an office of the Internal Revenue Service, or consult a tax expert.

#### Standard Deduction

In lieu of listing amounts paid for nonbusiness deductible items, under the Revenue Act of 1964, the taxpayer may elect to use the 10 per cent standard deduction, or the minimum standard deduction. However, both husband and wife must use the same method. The minimum standard deduction is computed as follows: \$200 (\$100 if married and filing separate returns) plus \$100 for each exemption claimed on Schedule A, of the return, including exemptions for age and blindness. The deduction is limited to \$1,000 (\$500 if married and filing a separate return). Consideration should be given to this provision in determining the amount to be entered on line 2 of the Tax Computation Schedule on page 2 of Form 1040-ES.

#### Other Provisions

Dividends paid out of a corporation's current or accumulated earnings are taxable. The first \$100 of such dividends are taxfree when the taxpayer takes

the dividend exclusion. On a joint return the exclusion may be up to \$200. Dividends received in 1965 do not qualify for a dividend credit.

An individual who is 65 or older may exclude from gross income, any capital gain attributable to the first \$20,000 of the sales price of his personal residence. Provided, the property has been owned and used by him as his principal residence for at least 5 years during the 8 year period preceding the sale.

The taxpayer who, because of employment, must engage a sitter for a child up to age 13, or for a physically or mentally defective dependent, may qualify for deductions on expenses for this purpose.

The taxpayer may not exclude sick pay from taxable income for the first 30-day period, unless the regular pay was reduced by 25 per cent or more.

The cost of business equipment with a useful life of four years or more may be subject to a credit of as much as 7 per cent.

#### Partnerships

The partnership itself is not subject to income tax, but is required to file an information return, Form 1065. Tax liability falls upon the individual partners. Simple agreements for the sharing of expenses, co-ownership and maintenance of property, and the like, are not considered partnerships, unless a profit element also is involved.

Where an actual partnership exists, partners would do well to seek expert advice in regard to tax liability. An Opinion of the Ohio Attorney General given in 1961 permits professional men to associate as partnerships under Ohio limited partnership law and thus make themselves eligible for favorable tax action under the U. S. Internal Revenue Act.

#### Professional Corporations

In 1961, the Ohio Legislature enacted Sections 1785.01 through 1785.08 of the Ohio Revised Code, authorizing members of certain professions, including physicians, to form professional associations. A number of other states have enacted similar legislation.

One of the primary purposes of the legislation was to make it possible for associations of professional persons to be treated as corporations for federal tax purposes.

A number of such professional associations have been incorporated under Ohio law, and have made application to IRS for special tax benefits. At latest report, none of these associations had been approved for special tax treatment. The Ohio State Medical Association has gone on record requesting the Internal Revenue Service to take no unfavorable action that would change regulations in regard to tax treatment of professional associations.

#### Provisions of the Keogh Law

The Keogh Act, or Public Law 87-792, permits physicians and other self-employed persons to claim



tax deductions for a portion of the contributions made by them to pension and retirement plans for themselves and their employees.

The American Medical Association now has a retirement plan for qualified members and their employees, information on which may be obtained from the AMA Chicago office, or the Ohio State Medical Association office.

### District Office and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are two districts in Ohio. Counties comprising each district follow:

**For the Cincinnati District** — Director of Internal Revenue, 550 Main Street, Cincinnati, Ohio 45202, comprising the following counties: Adams, Athens, Brown, Butler, Clark, Clermont, Coshocton, Clinton, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hamilton, Highland, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Miami, Montgomery, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Preble, Ross, Scioto, Union, Vinton, Warren, and Washington.

**For the Cleveland District** — Director of Internal Revenue, 220 St. Clair Ave., N. W., Cleveland, Ohio 44113; comprising the following counties: Allen, Ashland, Ashtabula, Auglaize, Belmont, Carroll, Champaign, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Erie, Fulton, Geauga, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa, Paulding, Portage, Putnam, Richland, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood, and Wyandot.

### INCOME TAX WITHHOLDINGS

Every employer who pays wages to one or more employees, where an employer-employee relationship exists, must withhold from such wages and pay over to the Federal Government periodically an amount prescribed by law.

The amount to be deducted from each pay check may be determined by referring to the *Employer's Tax Guide Circular E* after having the employee fill out Form W-4 to determine the number of exemptions he claims. The handbook is supplied by the District Office of the Director of Internal Revenue.

The amount deducted is paid to the District Office of the Director of Internal Revenue together with report on Form 941, for the calendar quarter, during the month immediately following the quarter for which deductions are made. (Social Security taxes are reported on this same form.) Social security taxes withheld from employees' wages and the employer's matching contributions are reported on this

same form. Self-employment social security taxes are not reported on this form.

The employer is required to give each employee from whose wages he has withheld income tax during the year a statement in duplicate showing the amount of tax withheld and wages paid for that year. Forms W-2 in quadruplicate are supplied for this purpose. The original copy of Form W-2 is to be filed with the Employer's Quarterly Federal Tax Return, Form 941, for the last quarter. The second and third copies are furnished the employee and the fourth copy retained by the employer for his records. Statements must be furnished employees and reports made to the government between January 1 and January 31, for the previous year.

### Deposit of Withholdings

An employer who withholds as much as \$100 per month for the purposes of income tax liability and F.I.C.A. liability (employer's and employee's shares) shall take these funds with Form 450 to a bank and deposit them. The bank transmits this form to the Federal Reserve Bank in Cleveland for validation, after which it is returned directly to the employer. The depository receipt, Form 450, is then eligible for use.

### Report of Funds Paid

Payments made during the year for interest of \$10.00 or more, rents, or commissions, not subject to withholdings of \$600.00 or more and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 28 of the following year to the Director, Internal Revenue Service Center, 222 East Central Parkway, Cincinnati, Ohio 45202.

### UNEMPLOYMENT TAX

Physicians or other employers who have **three or more** employees, including other physicians, nurses, receptionists, technicians, office workers, etc., are subject to the Ohio Unemployment Compensation Tax. Those who have **four or more** are liable also for the Federal Unemployment Insurance Tax.

In professional associations incorporated under Ohio S. B. 550, members of the group are counted as employees.

### Ohio Unemployment Compensation Tax

In general, employment of **three or more persons** renders the employer liable for this tax. (Excluded from the number of employees is a minor who does short-time work but whose principal occupation is that of student; an extra worker who works not more than one day in a week; also a person doing casual labor not in the course of the employer's regular business.) A physician who is in doubt as to his liability, should request clarification from the Ohio Bureau of Unemployment Compensation, Columbus.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau.

The tax rate is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This shows how the rate for the employer for that year was calculated. Rates for 1966 start at 0.6 per cent and may go as high as 4.7 per cent. Only the first \$3,000 paid by any employer to any one individual "in employment" within a calendar year is taxable. The same minimum has been in effect since 1963 through an emergency rate assessment.

Penalties are specified in the Ohio Code for failure to comply with provisions of the law.

Liable employers should furnish a form BUC-400 to each employee upon separation. These forms may be obtained from the local employment office. If the employee files a claim for benefits, the Bureau will request separation and wage information from the employer. It is imperative that this form requesting separation information be returned to the Bureau within seven days of its receipt.

### Federal Unemployment Tax

The Federal Unemployment Insurance Tax applies to employers who have had four or more persons on their payrolls on 20 or more days in the calendar year, each of the 20 days being in different calendar weeks. It is payable to the District Director of Internal Revenue by January 31 for the previous year. The gross tax is 3.1 per cent for 1966 on all individual wages up to \$3,000 and is collected from the employer—the employee making no contribution. A credit not to exceed 90 per cent of 3.0 per cent of the federal tax is allowed on all payrolls which were reported to the state unemployment compensation agency, (see under Ohio Unemployment Compensation Tax) and the state tax paid by January 31. If an employer has paid his state unemployment tax in full, the Federal tax is reduced to four-tenths of 1 per cent.

### OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay compensation to workmen for injury or occupational disease and compensation to dependents for death occasioned in the course of or arising out of employment.

Every employer in the state employing three or more employees regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year, and to contribute to the State Insurance and Occupational Disease Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect under bond to comply with the provisions of the law by self-insuring the risk.)

Employers of less than three employees may vol-

untarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached by August 1 for the first half of the year, and by February 1 for the second half of the year. Another requirement is an advance permanent deposit based on eight months estimated payroll for the periods January 1 - August 31 and July 1 - February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus.

### Disabled Workmen's Relief Fund

Effective in 1959, the Ohio General Assembly increased permanent and total disability benefits and enacted Senate Bill No. 472 to finance this increase by levy of an excise tax on employers of 3 cents per \$100 of total aggregate gross payroll. This excise tax applies to employers of three or more employees, and to employers of less than three persons who have voluntarily subscribed to the Workmen's Compensation Insurance Fund; also self-insured employers. Report for the calendar year with premium is due by March 1 of the following year.

### OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

Personal Property Tax Forms 910 and 911, now 8½x11½ inches, may be obtained from the county auditor's office.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its true value. Counting the year of purchase as a half year, a depreciation of 10 per cent annually from cost will be allowed until such equipment reaches a value of 30 per cent. It should stop at that figure for a year. Then such office equipment may be reduced 2½ per cent each year until it reaches a minimum value of 20 per cent, which value should be kept as a utility value.

It should also be noted that personal investments such as corporation stocks, notes or mortgages, etc., are also taxable and must be returned in the personal property tax report along with business property.

When a physician opens his practice (or a person starts in business) during the calendar year, he is required by law within 90 days of time of opening to list all his taxable property, as of the date he engaged in practice. The valuation of all taxable property to be returned for taxation is determined by multiplying



the value by the number of remaining months in the year and dividing the result by 12.

Forms 937 and 902, obtained from the County Auditor, must be filed with the Personal Property Tax return to obtain a lesser value than 20 per cent.

**Returns should be filed in duplicate.** The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

Accounts receivable are to be listed in accordance with Section 57711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually, or the last day of the fiscal year.

As defined in Section 5701.07 R. C., credits mean "the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

It should be understood that there is no discrimination in the foregoing provisions against physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a credit basis, must return his accounts receivable for taxation.

## OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

In Section 5739.01, under the definition "vendor,"

the Revised Code states: "Physicians, dentists, hospitals and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors."

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by non-profit institutions and persons licensed to practice veterinary medicine, surgery and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service or the practice of veterinary medicine, surgery and dentistry."

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Office of the Tax Commissioner to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Office of the Tax Commissioner, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014, "The Quarterly Consumers Return."

Forms are routinely sent to physicians on record, who have been assigned a Use Tax account number. Physicians who have not been assigned an account number should write to the Office of the Tax Commissioner.

## CITY PAYROLL TAXES

Many municipalities in Ohio have enacted laws imposing income taxes on wage earners and placing the primary responsibility on the employer to make payroll deductions, file forms and pay taxes to the city government. This responsibility falls upon a self-employed person, such as a physician in private practice.

Laws vary as to liability of a person who earns the major part of his income in one community and resides in another. The physician who moves into a new location would do well to inquire as to local tax laws.

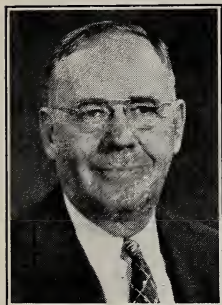
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The American Medical Writers Association honored Dr. Irvine H. Page, Cleveland, as the "medical writers' writer" of 1965. The director of research at the Cleveland Clinic, Dr. Page is editorial director for a nationally distributed medical magazine.

## C. C. Sherburne, OSMA Past-President, Former President of OMI, Is Dead

Clifford C. Sherburne, M. D., outstanding Columbus physician, Past-President of the Ohio State Medical Association, Delegate of long standing to the American Medical Association and a tireless worker in behalf of medicine, died on November 13 at the age of 71.

Dr. Sherburne was first elected to The Council of OSMA in 1935 as Councilor of the Tenth District, was named President-Elect of the State Association in 1942 and served as President the following year.



Dr. Sherburne

He has served as member and often as chairman of numerous state-level committees, among them the Committees on National Emergency Medical Service, National Defense, Civil Defense, Disaster Medical Care and the Special Insurance Committee. He was one of the organizers of Ohio Medical Indemnity, served as its president and for many years as a member of the

OMI board of directors. Among additional responsibilities with OMI, he served as vice-president and president of the executive committee. He was also on the board of directors of the Ohio Medical Political Action Committee (OMPAC).

Dr. Sherburne served as a member of the House of Delegates of the AMA from 1941 to 1961 and during that period introduced many resolutions in behalf of the Ohio delegation. He also served on a number of committees of the AMA House; was chairman in 1957 of the Reference Committee on Amendments to the Constitution and Bylaws, and in 1955 was chairman of the Committee on Reports of Officers. On the local level, he was a Past-President of the Academy of Medicine of Columbus and Franklin County and worked on many projects of the society.

Most of his early life was spent in the Newark vicinity where his parents brought him from Greenville, Illinois, at the age of two. He attended elementary and high schools in Newark and graduated from Denison University in 1917. His medical degree was received from Washington University School of Medicine in 1921. After an internship and residency training in St. Louis and a brief stay in Flint, Michi-

### Doctor Sherburne

The sudden death of Dr. C. C. "Sherb" Sherburne was a shock to many people — his patients and a host of friends.

He died of a heart attack as he was leaving the Ohio State Stadium after the game Saturday. If it was his time to go, that is the way he would have wanted it.

Duty and loyalty were his guideposts. He was dedicated to medicine, and filled the role of family doctor as well as serving local, state and national medical councils.

Although he was 71 he never lost interest in his college and his fraternity. He and Denison classmates made a ritual of hunting mushrooms in the Welsh Hills on every Kentucky Derby Day. He always attended the Sigma Chi summer reunion.

A trustee of the Columbus Auto Club for 20 years, he had been its president and loved to help the club's annual orphan picnic and its distribution of Christmas gifts to orphans. He and Mrs. Sherburne had no children.

As a doctor he had coped with death for 40 years, yet he shunned the airplane.

He was the kind of doctor who made you feel better the minute you saw him. He was skilled in medicine, but his greatest skill was friendship. — Reprinted by permission from the *Columbus Citizen-Journal*.

gan, he returned to Columbus to practice and for most of his professional career specialized in internal medicine. Among appointments he was on the faculty of the Ohio State University College of Medicine and in recent years held the title of emeritus professor of medicine.

Dr. Sherburne was a member of Sigma Chi fraternity and Nu Sigma Nu professional fraternity. Other affiliations included memberships in the Masonic Lodge, the Episcopal Church, Rotary Club, and Auto Club, of which he was a former president. A sports enthusiast since college days, he was stricken while leaving the OSU-Iowa football game. Services were held in Columbus with burial in Newark. His widow survives.



**James F. Berwald, M.D.**, Cleveland Heights; Western Reserve University School of Medicine, 1944; aged 55; died October 13; member of the Ohio State Medical Association; former member of the American Medical Association, member of the American Psychiatric Association and the American Psychoanalytic Association. A practicing psychiatrist in Cleveland, Dr. Berwald was head of the child psychiatric clinic at University Hospitals and a member of the Western Reserve University faculty. He was a veteran of World War II. Survivors include his widow, his mother, a brother and two sisters.

**Tressa M. Bradish, M.D.**, Toledo; Eclectic Medical College, Cincinnati, 1916; aged 82; died October 6. A native of Albion, Pa., Dr. Bradish moved to Toledo in 1919 and practiced there for many years. Among professional appointments, she was medical examiner for the local YWCA and for the area nurses' association. Dr. Ethel Mae Hite, of Toledo, is a sister. A brother also survives.

**Merle C. Davis, M.D.**, Leipsic; Western Reserve University School of Medicine, 1912; aged 86; died October 2. A native of Putnam County, Dr. Davis returned there to live after practicing in Cleveland until the 1930's. He was a member of the Methodist Church.

**Ellery P. Edwards, M.D.**, Cleveland; Western Reserve University School of Medicine, 1909; aged 87; died October 18; member of the Ohio State Medical Association and the American Medical Association. A physician of long standing in the Greater Cleveland area, Dr. Edwards specialized in public health work and particularly tuberculosis. He was health commissioner for Cleveland Heights and physician for the local schools. Affiliations included membership in the Congregational Church and in the Professional Men's Club. His widow, two sons and two daughters survive.

**John Leonard Frazer, M.D.**, Wellston; Ohio State University College of Medicine, 1929; aged 63; died October 23; member of the Ohio State Medical Association and the American Medical Association. Dr. Frazer's entire professional career was served in Jackson County, where he moved after completing his internship in Cincinnati. In addition to his professional associations, he was active in numerous community affairs; was a member of the Rotary Club, the Methodist Church and several Masonic bodies. His widow, a son and a daughter survive.

**William P. Hanna, M.D.**, Brewster; Starling Medical College, Columbus, 1906; aged 86; died October 5; member of the Ohio State Medical Association and the American Medical Association. Dr. Hanna devoted some 55 years to practice in the Brewster area before his retirement five years ago. He was active also in numerous community and business affairs of the town; was a member of the

Methodist Church, the Lions Club and the Masonic Lodge. Survivors include his widow, a daughter, two sisters, a brother and a half-brother.

**Vincent G. Herman, M.D.**, Campbell and Hubbard; Creighton University School of Medicine, 1941; aged 59; died October 8; member of the Ohio State Medical Association and the American Medical Association. A native of Youngstown, Dr. Herman took his internship there and opened his office for general practice in neighboring Campbell. During World War II he served in the Navy Medical Corps. A member of the Catholic Church, he is survived by his widow, two sons, two daughters, a brother and two sisters. For about a year the family residence has been in Hubbard.

**Raphael Isaacs, M.D.**, Chicago; University of Cincinnati College of Medicine, 1918; aged 74; died October 26. A native of Cincinnati, Dr. Isaacs left Ohio early in his career.

**Ray W. Kissane, M.D.**, Columbus; Ohio State University College of Medicine, 1918; aged 71; died October 15; member of the Ohio State Medical Association, the American Medical Association, American College of Cardiology, American College of Chest Physicians, American Society of Internal Medicine; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine. A practicing physician of long standing in Columbus, Dr. Kissane specialized in cardiology and was professor of medicine at Ohio State University College of Medicine. He was a member of the Episcopal Church. Among survivors are his widow, a daughter and a sister.

**John Lewis Maurer, M.D.**, Santa Ana, Calif. (formerly of West Liberty); University of Cincinnati College of Medicine, 1928; aged 70; died October 8; member of the Ohio State Medical Association and the American Medical Association. Dr. Maurer practiced medicine in West Liberty from 1928 to 1953, moving to California shortly thereafter. He was a member of several Masonic bodies and a member of the Presbyterian Church. Surviving are his widow, a daughter, a brother and two sisters.

**Henry J. Meister, M.D.**, Warren; Cornell University Medical College, 1916; aged 76; died October 31; member of the Ohio State Medical Association and the American Medical Association. A practicing physician in Warren for some 44 years, Dr. Meister was active also in civic, cultural and sports organizations of the community. During World War I, he served overseas in the Medical Corps. His widow, a daughter and a sister survive.

**Francis Carl Meszaros, M.D.**, Akron; University of Budapest Faculty of Medicine, 1923; aged 67; died September 3; member of the Ohio State Medical Association and the American Medical Association. A former physician of Hungary, Dr. Meszaros took

special training in this country before opening a practice in Akron. He became a member of the Summit County Medical Society in 1955.

**James D. Parker, M.D., Sandusky;** Cleveland-Pulte Medical College, 1900; aged 89; died October 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Parker's entire medical career of some 55 years was served in Sandusky where he retired in 1955. Among civic activities, he served many years as a member of the local board of education and was its president for 10 years. He was a member of the Methodist Church and several Masonic bodies. Two sons practice medicine in Sandusky, Dr. Watson D. and Dr. Lester G. Parker. Another son and two daughters also survive.

**J. Henry Schroeder, M.D., Cincinnati;** Cincinnati College of Medicine and Surgery, 1902; aged 79; died October 14. A practitioner of long standing in Cincinnati, Dr. Schroeder was former examiner for the Federal Aviation Agency. He was a veteran of World War I. A daughter and a son survive.

**Jacob Shapiro, M.D., Birmingham, Mich.;** University of Michigan Medical School, 1929; aged 61; died October 13; former member of the Ohio State Medical Association; member of the American Academy of General Practice. Formerly a practitioner in Cleveland and later in Delphos, Dr. Shapiro moved to the Detroit area shortly after World War II, during which he served in the Army Medical Corps. Survivors include his widow, a son, a daughter, his mother, a brother and two sisters.

**Ralph B. Thompson, Cleveland Heights;** Western Reserve University School of Medicine, 1913; aged 77; died October 5; member of the Ohio State Medical Association and the American Medical Association. Dr. Thompson retired in 1963 after practicing in the Cleveland area for 50 years. Among affiliations, he was a member of the Masonic Lodge. Surviving are his widow, a son and a daughter.

**Michael Vaitenas, M.D., Cleveland;** Kaunas Medical Institute, Lithuania, 1938; aged 54; died July 11.

A native of Lithuania and former practitioner in Europe, Dr. Vaitenas was licensed in Ohio in 1951 and practiced in Cleveland.

**Charlotte Winnemore, M.D., Columbus;** Woman's Medical College of Pennsylvania, 1926; aged 65; died July 29; member of the Ohio State Medical Association and the American Medical Association. For some 15 years, Dr. Winnemore was medical director of the Area Red Cross Blood Program with headquarters in Columbus. Formerly on the faculty at Ohio State University, she was associated with the student health service. For a number of years also she was associated with the Planned Parenthood League. A member of the Society of Friends, she is survived by a sister.

### Hospital Staffs Receive Copies of AMA Utilization Handbook

*Utilization Review — A Handbook for the Medical Staff* was scheduled for recent distribution by the American Medical Association to the chiefs of staff of all nonfederal, short-term, and other special hospitals.

Developed by the AMA's Department of Hospitals and Medical Facilities at the direction of the Committee on Medical Facilities of the Council on Medical Service, the Handbook is intended to assist in carrying out the recommendation that medical staffs of hospitals be urged and assisted to form utilization committees, as adopted by the AMA House of Delegates at the December 1964 Clinical Convention.

Dr. Edward A. Gall, Cincinnati General Hospital, will conduct the 22nd Annual Tumor Seminar of the San Antonio Society of Pathologists, Saturday, December 4, 1965, at 9:00 A.M., Auditorium, Building 1026, Brooke General Hospital, Fort Sam Houston. Slide sets at \$7.50 per set may be ordered from the Secretary - Treasurer, M. W. Delmer, M.D., Baptist Memorial Hospital, San Antonio, Texas 78205.

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APPLICATION FOR SPACE, SCIENTIFIC AND HEALTH EDUCATION  
EXHIBITS, OHIO STATE MEDICAL ASSOCIATION, 1966 ANNUAL MEETING,  
SHERATON-CLEVELAND HOTEL, CLEVELAND, OHIO, MAY 24 - 28

1. Title of Exhibit: \_\_\_\_\_

2. Name(s) of Exhibitor(s): \_\_\_\_\_

\_\_\_\_\_

Institution (if desired): \_\_\_\_\_

City \_\_\_\_\_

3. Do you have a built-in exhibit? \_\_\_\_\_

4. Description of Exhibit: (Attach 200 word description to this blank)

5. Exhibit will consist of the following: (Check which)

Charts and posters \_\_\_\_\_ Photographs \_\_\_\_\_ Drawings \_\_\_\_\_ X-rays \_\_\_\_\_

Specimens \_\_\_\_\_ Moulages \_\_\_\_\_ Other material \_\_\_\_\_

(Describe)

6. Booth Requirements:

Amount of wall space needed? \_\_\_\_\_

Back wall \_\_\_\_\_ Side walls \_\_\_\_\_

Square feet needed? \_\_\_\_\_

Shelf desired? (yes or no) \_\_\_\_\_

7. Transparency Cases:

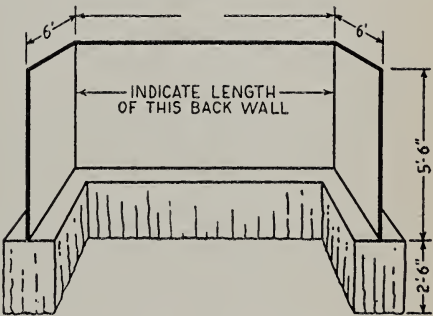
Needed? (yes or no) \_\_\_\_\_

If answer "yes," give following information:

Number of transparencies to be shown and size of each \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Booths will have a back wall and two side walls. The side walls of all booths will be six feet wide. Back wall and side walls are eight feet high. If standard shelf is used, only 5½ ft. will be available for exhibit material. For most exhibits, a back wall, eight feet long will be sufficient. With the two 6 ft. long side walls, this gives a total of 110 square feet of wall space.

(It is suggested that transparencies should be no larger than 10 by 12 inches in order to conserve space. For size of view boxes which will be supplied by the Ohio State Medical Association if requested by you and how films should be mounted, see pages 3 and 4 of folder "Regulations and Information, Scientific and Health Education Exhibits, Ohio State Medical Association" which will be supplied to all applicants.

Date \_\_\_\_\_

Signature of Applicant

Mailing Address, Street

City, State, Zip Code

SEND APPLICATION TO: COMMITTEE ON SCIENTIFIC AND HEALTH EDUCATION EXHIBITS,  
OHIO STATE MEDICAL ASSOCIATION, 79 EAST STATE STREET, COLUMBUS, OHIO 43215

DEADLINE FOR FILING APPLICATIONS, JANUARY 30, 1966

# Activities of County Societies...

## First District

(COUNCILOR: ROBERT E. HOWARD, M. D., CINCINNATI)

### BUTLER

Officers, directors, and executive secretaries of the three American Cancer Society units in Butler County were dinner guests of the Butler County Medical Society on September 22 at the Elks Country Club, Hamilton-Middletown Road.

This was the first annual combined Butler County Medical Society — American Cancer Society meeting. There are ACS units in the Middletown, Hamilton and Oxford areas.

Dr. William Newton, director of the Departments of Pathology, Children's Hospital, Columbus, spoke on the chemical treatment of children's tumors. — Adapted from *Middletown-Journal*.

### HAMILTON

Dr. James Z. Appel, Lancaster, Pa., President of the American Medical Association, spoke at the October 12 meeting of the Academy of Medicine of Cincinnati on the topic "Is There a 'New World' for Medicine?"

The Academy held a special meeting on November 9 to highlight local observance of Community Health Week. Speaker for the occasion was Dr. Stewart G. Wolf, head of the Department of Medicine at the University of Oklahoma School of Medicine.

Theme for the November 16 meeting of the Academy was "Complications Occurring in Patients Taking Oral Contraceptives." Program speaker was Dr. David B. Clark, professor of neurology and director of the Department of Neurology, University of Kentucky School of Medicine, Lexington.

## Second District

(COUNCILOR: THEODORE L. LIGHT, M. D., DAYTON)

### DARKE

Dr. Nicholas Thompson, Dayton, was speaker for the November 16 meeting of the Darke County Medical Society, and discussed the subject, "Cancer of the Female Reproductive Tract." The meeting was held in Wayne Memorial Hospital, Greenville, following dinner.

## Third District

(COUNCILOR: FREDERICK T. MERCHANT, M. D., MARION)

### ALLEN

The Lima and Allen County Academy of Medicine held its regular meeting on October 20 with 78 members and guests present. The speaker, Dr. Benjamin Felson, chairman, and professor of radiology at the University of Cincinnati College of Medicine, spoke on "Fundamentals of Chest Roentgenology".

Dr. Frederick T. Merchant, Councilor for the Third District, was present as a guest.

Drs. Hector A. Buch, Peter W. Reed, Liang Yee (Douglas) Soo and Dixie A. Soo were elected members in the academy. — T. D. Allison, M.D., Secretary-Treasurer.

### AUGLAIZE

At a recent meeting, the Auglaize County Medical Society voted to hold regular meetings on the first Thursday of each month, except July, at a place to be designated.



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JOHN H. NICHOLS, M. D., Medical Director    G. PAULINE WELLS, R. N., Admin. Director    HERBERT A. SIHLER, Jr., Pres.  
MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association

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## Fourth District

(COUNCILOR: ROBERT N. SMITH, M. D., TOLEDO)

### LUCAS

The Academy of Medicine of Toledo and Lucas County had on its calendar for October the following featured programs:

October 2 — Open house at the Academy building's new addition.

October 15 — Specialties Section program: "Delivery Room Pediatrics," with guest speaker, Dr. Paul Taylor, Department of Pediatrics, Elizabeth Steele Magee Hospital, Pittsburgh, Pa.

October 29 — Specialties Section; "Humoral Syndromes Association with Cancer," with guest speaker, Dr. Mortimer B. Lipsett, head of the endocrinology service, National Cancer Institute, Bethesda, Md. The program was co-sponsored by the American Cancer Society.

Some 140 high school students responded to an invitation by the Academy of Medicine's medical vocational committee to attend an orientation meeting on medicine as a career. With many of the students accompanied by parents, the group overflowed the Academy building auditorium, according to a newspaper report. Members of the committee headed by Dr. Henry R. Silverman, showed the film, "The Making of a Doctor," and discussed the various aspects of a medical career.

Students were invited to use books on vocations from the Academy's library, and individual students were requested to arrange a day with a doctor.

## Fifth District

(COUNCILOR: P. JOHN ROBECHKE, M. D., CLEVELAND)

### CUYAHOGA

Fifty-Year awards, presented for outstanding contributions as members of the medical profession over a period of half a century, were given to nine persons

at the October 15 meeting of the Academy of Medicine of Cleveland and Cuyahoga County.

The fifty-year physicians are Dr. Rafael Dominguez, Dr. Charles H. Garvin, Dr. William B. Markus, Dr. Julius W. McCall, Dr. Harry D. Piercy, Dr. Rudolph S. Reich, Dr. James L. Reyecraft, Dr. Adam E. Sitkoski, and Dr. Bessie G. Wiesstien.

Presentation of the Fifty-Year Awards were made in behalf of the State Association and the local Academy by Dr. P. John Robeck, Cleveland, Fifth District Councilor.

The 28th Annual Lower Lecture was given on the same evening. Lecturer for the occasion was William Frank Libby, director of the Institute of Geophysics and Planetary Physics, and professor of chemistry, University of California. Title of his talk was "Radiocarbon Dating."

## Sixth District

(COUNCILOR: EDWIN R. WESTBROOK, M. D., WARREN)

### MAHONING


On October 19, members of the Mahoning County Medical Society met with those of the Corydon Palmer Dental Society at the Mural Room. Speaker was William T. Heron, Ph.D., whose topic was "The Uses and Abuses of Hypnosis in Medicine and Dentistry."

The Society sponsored a day-long "Community Health Care Symposium," on November 11. Panelists represented 12 different community groups interested in medical and health facilities, with the forum open to the public.

### PORTAGE

The "Population Explosion" was the theme of a talk by guest speaker Dr. H. Durtis Wood, of Philadelphia, at the September meeting of the Portage County Medical Society.

A practicing physician of long standing, Dr. Wood



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is now the medical field director for the Association for Voluntary Sterilization, Inc.

### Seventh District

(COUNCILOR: BENJAMIN C. DIEFENBACH, M. D.,  
MARTINS FERRY)

#### BELMONT

The Belmont County Medical Society and the Auxiliary met on October 21 at the Belmont Hills Country Club for a late afternoon program and dinner. The subject, "Techniques of Arteriography," was discussed by Dr. William Howland and Dr. Joseph Curry.

### Eighth District

(COUNCILOR: ROBERT C. BEARDSLEY, M. D.,  
ZANESVILLE)

#### GUERNSEY

"Some Historical Developments in Society," a discussion of the National Health Service in England vs. Medicare, was presented at the November 2 meeting of the Guernsey County Medical Society. Speaker was Dr. John B. K. Smith, Marlboro, N. J., psychiatrist who holds several teaching appointments in New Jersey and New York.

The dinner meeting was held at the Cambridge Country Club.

### Tenth District

(COUNCILOR: RICHARD L. FULTON, M. D., COLUMBUS)

#### FRANKLIN

Dr. Frank G. Slaughter, former practicing physician and now well-known author and lecturer, was guest spaker for the October 18 meeting of the Academy of Medicine of Columbus and Franklin County. His topic was "The Physician's Heritage." The dinner meeting for members and wives was held in the Sheraton-Columbus Motor Hotel.

### Eleventh District

(COUNCILOR: WILLIAM R. SCHULTZ, M. D., WOOSTER)

#### LORAIN

The regular meeting of Lorain County Medical Society was held at Oberlin Inn on Tuesday, October 12, preceded by a social hour and dinner.

The following 12 physicians were unanimously elected to active membership in the Society: Andrew D. Balunek, M.D. (Avon Lake); Clarence E. Everhart, M. D. (Elyria); Hugh Benedict Foley, M. D. (Elyria); Ted Alan Gray, M. D. (Oberlin); Wolf

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W. Greiffenhagen, M.D. (Oberlin); Feite F. Hofman, M.D. (Oberlin); Stanley Lunas, M.D. (N. Ridgeville); Delbert Dean Mason, M.D. (Oberlin); Rudy G. Moc, M.D. (Elyria); John Harvey Paige, M.D. (Lorain); William Davis Reed, M.D. (Lorain); Joseph Sciarrotta, M.D. (Lorain).

Second reading and election to associate membership was accorded to Drs. Eino Kooba (Lorain) and Thomas Sfiligoj (Lorain) and the application of Dr. Emmanuel L. Onlayao (North Ridgeville) received a first reading.

Appointment of Nominating Committee for 1966 slate of officers was announced by President John W. Wherry as follows: John Halley, M.D., (chairman), Henry Kleinhenz, M.D., and Roy E. Hayes, M.D.

The purpose of a Committee on Hospital Relations, as requested by The Council of the Ohio State Medical Association, was outlined to the membership. Appointment of the undermentioned members to serve on Lorain County Medical Society Committee on Hospital Relations was announced: R. M. Arnold, M.D. (Avon Lake), Chairman; Denis Radefeld, M.D. (Lorain); R. P. Hardwig, M.D. (Lorain); R. D. Berkebile, M.D., (Elyria); J. H. Warner, M.D.

(Oberlin); G. R. Wiseman, M.D. (Amherst); J. A. Nista, M.D. (Wellington).

Paul J. Kopsch, M.D. prepared and read a moving memorial address for the late Dr. A. L. Pryatel, Lorain physician, and all present stood in silent tribute to his memory.

Business affairs of the Society included a report by Dr. R. G. Thomas, chairman of the Tumor Registry Committee; reviewing how the Lorain County Tumor Registry operates in relation to "follow-ups", utilization of physicians, provision of statistical data, etc., discussion centered on the source of financial support available, costs to be faced in the future, adequate office space and personnel.

The Report of the Constitution Committee, which was considered and approved by Council recently, was presented to the membership, together with copies of the suggested amendments.

The membership was reminded of the official action by The Council of the Ohio State Medical Association approving inclusion of OMPAC-AMPAC dues with the regular billing for dues, and the purpose of this was explained. Business concluded with announcements of various seminars and scientific programs scheduled for the future.

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# Woman's Auxiliary Highlights ...

By MRS. S. L. MELTZER, Publicity Committee  
Chairman, 2442 Dorman Dr., Portsmouth

THE GIFT OF GOOD HEALTH transcends all other gifts. Doctors' wives are singularly fortunate in, that to some measure at least, they are in a position to help steadily in the effort to make possible the gift of good health for their individual communities. One radio or television broadcast that sends even one mother to the doctor for a child's immunization, by way of example, is in effect the giving of such a gift. Contributing to AMA-ERF to lend needed help to medical schools and medical students is certainly another such manifestation. Providing student nurse scholarships is most surely another type of gift. There are innumerable others.

At this Holiday Season, then, when we are all particularly gift-conscious, it might be well to remind ourselves how often a local auxiliary can play Santa Claus — not only at Christmas but the whole year long! After all, the gift of health can be packaged in so many different ways . . .

## Miles and Miles

Perhaps someone can come up with a theme song for our State President, to be sung particularly and lustily during the fall months when she is dashing north, south, east and west, frantically trying to cover all the district meetings. We haven't lost a President yet in the mad rush, but frankly we wonder how she stands up under the terrific pressure. The President-Elect is often caught up in the whirl too. Guess the answer lies in that significant word "dedication" and its companion piece "satisfaction" at the privilege of meeting doctors' wives from here, there and everywhere. And trying — and hoping — to be of some help.

Speaking of district meetings, your reporter regrets that she cannot feature those important get-togethers in this column. There just isn't the space to do justice to the highly interesting but lengthy accounts that have come in. Equal space would have to be given — and it just isn't available! Sorry . . .

## Around the State

The Allen County auxiliary paid special honor to three of its members recently — Mrs. Karl F. Ritter, a member of the National Board of directors and former National finance director and treasurer; Mrs. Russell L. Wiessinger, state treasurer; and Mrs. Howard C. Kingsbery, Third District director. The group enjoyed a luncheon as guests of the Sisters

of Mercy of St. Rita's Hospital, an annual event. Mrs. James Baker, president, introduced Sister Mary Caroline, hospital administrator, who welcomed the doctors' wives.

Allen County was one of six auxiliaries throughout the country given an AMA-ERF award at the National Convention in June. Mrs. Ritter, a past national AMA-ERF chairman herself, presented the award to Mrs. William E. Noble, last year's local chairman. Mrs. F. D. Rodabaugh, program chairman, introduced members of a panel who took the women back to the early 1900's in an eye-opening discussion on "Life as a Doctor's Wife." The panel included: Mrs. Paul Stueber, Mrs. H. A. Thomas, Mrs. W. E. Noble and Mrs. W. B. Light. Mrs. Gene E. Wright, membership chairman, introduced five new members: Mrs. Hector Buch, Mrs. Robert Curry, Mrs. Peter Reed, Mrs. Ernest Schoeniger and Mrs. Dennis Steinecker. She also welcomed two members-at-large: Mrs. Robert Herman and Mrs. R. H. Schaefer of Wapakoneta.

The Allen County women sponsored a film, "Medicine Man," on their local television station WIMA. It was shown on a Sunday following a football game. Excellent timing!

## "Gold Digger"

A silky, long-lashed young lady (she cut quite a mannequin's figure!) was in attendance at the annual Chrysanthemum Ball in November given by the Cuyahoga Auxiliary for AMA-ERF at the Hotel Sheraton-Cleveland. Mrs. Elden C. Weckesser, president, described Miss AMA-ERF as "a gold digger, but for a good cause." She performed an outstanding job of luring the greenbacks her way, we are reliably informed. A reception honored Cleveland's Dr. Charles L. Hudson, President-Elect of the American Medical Association. Mrs. George Spencer and Mrs. Arthur Scherbel were co-chairmen of the Ball festivities. Assisting them were Mrs. Charles Swan, Mrs. Vernon Hacker, Mrs. Charles Hubay, Mrs. Henry Crawford, Mrs. Milton Bobey, Mrs. Nelson Klamm, Mrs. George Petznick, Mrs. Fred Rittinger, Mrs. Paul O. Funk, Mrs. Reuben Gould and Mrs. Bert Treister.

Cuyahoga's silver anniversary celebration got off to a start the latter part of September with a membership luncheon. There were punch bowl toasts to 25 years of outstanding activities. To remember the milestones, the group presented "AUX Shows Her Medals, Or 25 Sterling Years," written by Mrs. Alvyn



W. Tramer. Another of the day's features was the presence of Mrs. John Chenault as guest speaker. Mrs. Chenault is a National Auxiliary director and a past National President.

### Pot Luck

It all turned out to be good luck when the Hamilton women brought favorite buffet dishes to their November luncheon meeting at the Academy of Medicine. Bearing the more dignified standard "Holiday Food Parade," the occasion featured members' recipes collected and published by Mrs. Richard S. Jolson, copies of which were distributed at the luncheon. Guest speaker was Mrs. Jayne Spain, president of Alvey-Ferguson Company, who demonstrated the efficiency of training the blind to operate conveyor systems at trade fairs throughout the world. Her topic was "No Man Is an Island." Mrs. Joseph H. Goldcamp was the day's program chairman. Mrs. Donald L. Jacobs and Mrs. Marvin McClellan served as hospitality chairmen. Mrs. William E. Heil was in charge of decorations and Mrs. Glen E. McPheron served as registrar. Mrs. John B. Hamblet headed the group of hostesses. Assisting at the Food Parade table were Mrs. Robert E. Price, Mrs. William E. Shaw, Mrs. Frank Scharold and Mrs. Neal Earley.

The Hamilton group's October meeting was honored by the presence of Dr. William B. Walsh of Washington, D. C., founder and president of Project HOPE, at the Four Seasons Marina. Highlights of the American hospital ship's voyages of mercy to Southeast Asia, Africa and South America were described by Dr. Walsh. Now in Philadelphia shipyards for overhauling, the SS HOPE will sail in January for Nicaragua on its fifth mission as a self-sufficient teaching hospital. Two young Cincinnati members of the HOPE staff — Miss Sally Thompson and Miss Elaine Besterman — were guests of honor at the meeting. Dr. Walsh was introduced by Mrs. Raul Florez, program chairman for the day. Mrs. Edward Devins served as vice-chairman. Members of the Dental Auxiliary were invited as auxiliary guests.

Proceeds from the Knox Auxiliary's October Book Review and Tea will go to AMA-ERF and the group's local project, The Golden Age Club. Approximately 225 women attended the function at which Mrs. Harry Schwartz, attorney from Columbus, reviewed

"Up the Down Staircase." Mrs. J. R. Claypool presided at the Tea table, assisted by Mrs. William Perle, president, and Mrs. O. W. Rapp. Committee in charge of arrangements included: Mrs. Julius Shamansky, chairman; Mrs. Raymond Lord, Mrs. Robert Sooy, Mrs. Gerald Wyker, Mrs. Rapp, Mrs. John Drake, Mrs. John Baube, Mrs. Henry Lapp and Mrs. C. E. Cassaday.

### Health Career Days

About 250 high school students attended the Paramedical Careers Tea sponsored recently by the Lucas Auxiliary. An informative program was presented by Mrs. Jane Musgrave, nutritionist; Mrs. Dorothy Siebert, public health nurse; William Reischman, bacteriologist; Mrs. Virginia Hostetter, medical record librarian and Mrs. Sylvia Wittman, assistant director of nursing education. Janet Dangler, a first year student at the Toledo Hospital School of Nursing, was awarded the group's nursing scholarship. Mrs. Daniel Wolff was chairman of the Paramedical Careers Tea, with Mrs. Robert Baim serving as co-chairman. Just a few days earlier, the Academy of Medicine invited high school students interested in becoming doctors to a special session headed by Dr. Henry R. Silverman of the Medical Vocation Committee. Over 140 students, most of them accompanied by parents, overflowed the auditorium. These high school seniors were invited to spend a day with a doctor. The students filled out cards and will be assigned to accompany various doctors on a day's rounds.

Montgomery County auxiliary came up with its Fifth Annual Careers Day in Dayton on October 30 at Patterson Co-Operative High School. In conjunction with that activity, the third annual Guidance Counselor Workshop was also held. This was the first time for "cross county" planning. Greene and Montgomery cooperated in the planning of the day's program, with two other counties sending observers. Three new fields were covered this year: Religion in Medicine, Hospital Mechanical Maintenance (engineers, plumbers, electricians) and Hospital Service Training (maids, aides, orderlies). Also included this year among the twenty fields covered were Medical Art and Photography, and Science Writing.

The principal speaker of the day was Dr. Charles E. Weaver, State Supervisor of Guidance Service. He addressed the entire assembly at both morning and

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afternoon sessions and conducted the Workshop which was also attended by principals, guidance counselors and interested teachers in the Montgomery and surrounding counties. Dr. Weaver discussed "The Interpretation of Significant Test Scores in Paramedical Careers" and the procedures and significance of the Nurse Training Act. Mrs. Malachi W. Sloan was in charge of information and registration for the day.

#### More Busy Days

"Teen-Agers in To-day's Society" was the topic of a panel discussion recently, following a luncheon of the **Mahoning Auxiliary** in the Jade Room of the Mural Building. Under the guidance of Mrs. John J. Turner, president, Mrs. Isadore Mendel and Mrs. W. Clare Reese, program chairmen, and Mrs. S. E. Tochtenhagen, social chairman, the occasion was designated an "open meeting" so that anyone interested in understanding and helping their teen-agers could attend. The panel included: Dr. Kurt Wegner, pediatrician; James O'Brien, chief of the Youngstown Welfare Department and Dr. Robert E. Hamlish, psychiatrist in charge of the Youngstown Adult Guidance Center.

A new book "Health Careers" is being added to book shelves of libraries and educational institutions all over **Lorain County**. The book is an accomplishment of the local auxiliary, under the chairmanship of Mrs. William Hassler. Seventeen careers in medicine are surveyed. For each of these, educational requirements are stated, with the names of schools and colleges in Ohio offering such instruction. Costs are given. Also included are information on scholarships and employment opportunities. The book is an extension of the auxiliary's effort to interest Lorain County men and women in careers in the medical field. The group annually awards two nursing scholarships.

The October meeting of the **Stark Auxiliary** was a luncheon at the Massillon Woman's Club. (An interesting sidelight — this group maintains a membership at the Club for the benefit of student nurses affiliating at Massillon State Hospital . . . the membership provides the opportunity for student nurses to use the facilities of the club during their leisure time in a home-like atmosphere away from the confines of the hospital.) Mrs. William A. McCrea, president, presided at the business session following the luncheon. Mrs. Joseph Rabin of Canton presented a lively, entertaining one-woman show "Curtain Going Up." Mrs. Rabin is a talented veteran of the theatre, experienced in all of its phases and has appeared as a performer in innumerable productions. Mrs. George Swan and Mrs. Max Haas were co-chairmen for the October event.

#### Merry Christmas!

May the gifts of love, happiness and good health be yours this Holiday Season — and every day thereafter.

## Bureau of Workmen's Compensation Reports Some Misunderstanding of 'Usual and Customary Fee'

The Bureau of Workmen's Compensation, Ohio Industrial Commission, has informed the OSMA that there appears to be considerable misunderstanding among Ohio physicians of the Bureau's "usual and customary fee" program which became effective October 10.

For patients treated on and after October 10, the Bureau pays the physician the same usual and customary fee that he would charge a private patient for the same professional services.

According to Bureau information, many physicians have the misunderstanding that they can charge fees in any amount they choose under the new program.

Fees questioned by the Bureau may be forwarded to the OSMA for referral through the Councilor, to the appropriate mediation committee of the county medical society in which the physician submitting the questioned fee holds membership.

In addition, the Bureau, while following the usual and customary fee plan, still has the right to adjust a fee which it considers to be irregular.

In commenting on the program, OSMA President Henry A. Crawford said:

"It is the ethical and professional responsibility of every physician to participate in the usual and customary fee program in the same spirit of cooperation displayed by the Bureau of Workmen's Compensation in accepting OSMA's recommendation that this program be initiated.

"It is equally important that the county medical society committee to which cases are referred fulfill its responsibilities by acting on these cases without delay and with judicial fairness to all parties involved.

"I cannot emphasize too strongly," Dr. Crawford continued, "the fact that this program is a tremendous breakthrough in the relationship between the profession and government medical programs. It is a tremendous breakthrough because we have here a unique arrangement under which the agency has agreed to pay the physician a fair fee for his professional services.

"I strongly urge every physician to cooperate with this important program to his fullest extent. It is my sincere hope that this program will enjoy such success that it can serve as a model for other government-administered medical programs."

"The Pros and Cons of Maintaining Estrogen Therapy in the Postmenopausal Female" was the topic presented at the November 9 dinner meeting of the Fort Steuben Academy of Medicine. Dr. Arthur D. Hengerer, Albany, New York, was guest speaker. The meeting was held in the Fort Steuben Hotel, Steubenville.



# WARNING TO ALL MEMBERS!

- ★ Your Memberships in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA* (with other AMA publications), will expire on December 31. Here's how to renew them:
- ★ Mail your check immediately for dues to the SECRETARY-TREASURER of YOUR COUNTY MEDICAL SOCIETY.
- ★ OSMA dues are \$50.00. AMA membership dues are \$45.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer. Ohio Medical Political Action Committee — American Medical Political Action Committee contribution is \$25. OMPAC - AMPAC contribution is voluntary and is not tax deductible.
- ★ Many members probably will want to send one check to cover local, state and national dues. Make Check Payable To Your County Medical Society. If you do tender a separate check for AMA dues, make it payable to your County Medical Society and mark on the check the words "For 1966 AMA dues."
- ★ Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago and the OMPAC - AMPAC contribution to OMPAC.
- ★ Remember: As a part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA*, *Today's Health*, *The AMA News*, and an *AMA Specialty Journal* of choice.
- ★ Memberships and subscriptions are on a calendar year basis. Both expire on December 31. Renewal must be made by January 1, 1966, to keep them current.
- ★ The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should make his wishes known to the secretary-treasurer of his County Medical Society. After exemption has once been established, the member is automatically carried over from year to year, unless the status changes.

# Comments on Current Economic, Social And Professional Problems

*"It is hardly lack of due process for the Government to regulate that which it subsidizes."*  
— Justice Robert H. Jackson in AAA Supreme Court Case, 1942

## M. D.'s IN THE NEWS, OR POSITIVE PUBLIC RELATIONS

Currently running in *The Journal* is a column headed "M. D.'s in the News." In general, this column contains brief excerpts from newspapers throughout the State gathered from items sent in by a clipping service. The items for the most part are of particular local interest, but taken as a group they form a picture of what doctors of Ohio are doing for their respective communities.

Dr. John Doe is elected to the board of the local Chamber of Commerce; Dr. Joe Roe speaks before a local PTA group; Dr. Jim Brown examines Boy Scouts before their annual camp trip; Dr. Harry Jones demonstrates American surgical methods in a foreign hospital, etc.

It's a big occasion for a local CCL group when a doctor speaks to its members; local citizens take notice when a physician participates in civic activities; members of the Rotary Club are impressed when they hear the medical profession's point of view on matters of public concern.

The important point is that doctors are doing their parts in community activities and the local citizens are taking notice. This is positive public relations — or PR at the grass roots where the American public is most sensitive.

## VOLUNTEERS PROVE IT — DOCTORS DO MAKE NIGHT CALLS

As the result of a recent questionnaire sent to every member of the Mahoning County Medical Society, 40 doctors volunteered for the list for "any doctor" calls through the Medical-Dental Bureau. Obviously this list is in addition to the doctors who normally make emergency calls on their own patients.

A number of other County Medical Societies have had similar experiences when they asked for volunteers to take emergency calls.

The list is a comfort to persons in the area who know they can get a doctor when they need one, and a challenge to those who fall back on the unfounded criticism that "doctors won't make house calls." The list is concrete evidence that they do make such calls.

## IN THE SPIRIT OF THE SEASON — A PHYSICIAN'S PRAYER

*The Journal* has received requests to publish the prayer offered as an invocation to open the House of Delegates at the 1965 OSMA Annual Meeting. With the approach of the Christmas Season, doctors of all faiths may find inspiration in this, "A Physician's Prayer":

Thank you, O Lord, for the privilege of being a doctor — for letting me serve as Your instrument in ministering to the sick and afflicted.

May I always treat with reverence the human life, which You have brought into being.

Keep me constantly alert to see that the sacred right to live is never violated for even the least individual.

Deepen my love for people so that I will always give of myself gladly and generously to those stricken with illness and suffering.

Help me to listen patiently, diagnose carefully, prescribe conscientiously and follow through faithfully.

Teach me to blend gentleness with skill, to be a doctor with a heart as well as a mind.

Let me be calm without being cold, patient without being weak, and strong without being proud.

Help me, O Lord, to give encouragement, without over-confidence, to tell the truth without being blunt.

May I be prompt to relieve pain, quick to hold out the hand of honest hope.

Inspire me to show always a special tenderness for the poor and forgotten, for those who are broken in spirit as well as in body.

Grant that I may continually bring to my work the same soothing compassion which You so generously displayed centuries ago in healing the sick of Galilee.

And finally, O Divine Doctor, through my service to the sick, may I merit the heavenly reward which You promised in those thrilling words: "Come you blessed of my Father, possess you the kingdom prepared for you from the foundation of the world." (Matt. 25:24)



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### COMMITTEES

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**Committee on Public Relations and Economics**—Frederick P. Osgood, Toledo, Chairman (1969); Luther W. High, Millersburg (1970); John H. Budd, Cleveland (1968); John J. Cranley, Cincinnati (1967); Horace B. Davidson, Columbus (1966).

**Committee on Scientific Work**—Samuel Saslaw, Columbus, Chairman (1968); Jack Schreiber, Canfield (1970); Walter J. Zeiter, Cleveland (1970); John D. Battle, Jr., (1969); Harold J. Schneider, Cincinnati (1969); Isador Miller, Urbana (1968); William Hamelberg, Columbus (1967); F. A. Simeone, Cleveland (1967); Ralph K. Ramsayer, Canton (1966); G. Douglas Talbott, Dayton (1966).

**Committee on Care of the Aging**—Charles W. Stertzbach, Youngstown, Chairman; James O. Barr, Chagrin Falls; Dwight L. Becker, Lima; Robert A. Borden, Fremont; Edwin W. Burnes, Van Wert; Philip T. Doughten, New Philadelphia; Robert B. Elliott, Ada; George T. Harding, Sr., Worthington; Roger E. Heering, Columbus; M. Robert Huston, Millersburg; John S. Kozy, Toledo; Francis M. Lenhart, Defiance; Harold E. McDonald, Elyria; H. W. Porterfield, Columbus; Elliot W. Schilke, Springfield; Bernard A. Schwartz, Cincinnati; Clarence V. Smith, Canton; Joseph B. Stocklen, Cleveland; Don P. VanDyke, Kent; William M. Wells, Newark; Roger Williams, Columbus.

**Committee on Cancer**—Arthur G. James, Columbus, Chairman; Thomas D. Allison, Lima; Andrew M. Barone, Lima; William F. Boukalik, Cleveland; William J. Flynn, Youngstown; Douglas E. Graf, Cincinnati; Stanley O. Hoerr, Cleveland; William A. Newton, Jr., Columbus; W. D. Nusbaum, Lancaster; Arthur E. Rappoport, Youngstown; Carl A. Wilzbach, Cincinnati.

**Committee on Eye Care**—Arthur D. Collins, Cleveland, Chairman; Martin J. Cook, Springfield; Thomas L. Edwards, Lima; Robert H. Magnuson, Columbus; Russell J. Nicholl, Cleveland; Claude S. Perry, Columbus; Norman W. Pinschmidt, Gallipolis; Barnett R. Sakler, Cincinnati; Robert L. Willard, Toledo.

**Committee on Hospital Relations**—William R. Schultz, Wooster, Chairman; L. A. Black, Kenton; L. Fred Bissell, Aurora; Oscar W. Clarke, Gallipolis; Robert M. Craig, Dayton; John V. Emery, Willard; Harvey C. Gunderson, Toledo; Philip B. Hardymon, Columbus; Middleton H. Lambricht, Cleveland; Lloyd E. Larrick, Cincinnati; Joseph S. Lighty, Akron; James C. McLarnan, Mt. Vernon; Ben V. Myers, Elyria; Robert A. Tennant, Middletown; V. William Wagner, Port Clinton; William A. White, Canton.

**Committee on Insurance**—David A. Chambers, Cleveland, Chairman; William F. Bradley, Columbus; Walter A. Daniel, Tiffin; Chester R. Jablonoski, Cleveland; William A. Knapp, Zanesville; Marvin R. McClellan, Cincinnati; William Neal Archbold, Oliver Todd, Toledo; Robert E. Tschantz, Canton; Allan L. Wasserman, Dayton; John W. Wherry, Elyria; William A. White, Canton.

**Committee on Laboratory Medicine**—Horace B. Davidson, Columbus, Chairman; William H. Benham, Columbus; John B. Hazard, Cleveland; Melvin Oosting, Dayton; Arthur E. Rappoport, Youngstown; William Sinclair, Cleveland; Gilbert B. Stansell, Toledo; Philip B. Wasserman, Cincinnati.

**Committee on Legislation**—James T. Stephens, Oberlin, Chairman; Donald R. Brumley, Findlay; George D. J. Griffin, Cin-

cinnati; Jack L. Kraker, Lancaster; Maurice F. Lieber, Canton; Ralph F. Massie, Ironton; James C. McLarnan, Mt. Vernon; Robert E. Rinderknecht, Dover; John H. Sanders, Cleveland; Carl R. Swanbeck, Sandusky; William W. Trostel, Piqua.

**Committee on Maternal Health**—Anthony Ruppberg, Columbus, Chairman; Otis G. Austin, Medina; Raymond E. Barker, Columbus; William D. Beasley, Springfield; Keith R. Branderberry, Gallipolis; Thomas E. Byrne, Mentor; C. Raymond Crawley, Dover; Mel A. Davis, Columbus; Marion F. Detrick, Jr., Findlay; John P. Garvin, Columbus; Richard P. Glove, Cleveland; Robert A. Heilman, Columbus; John F. Hilabrand, Toledo; Robert E. Johnstone, Cincinnati; Albert A. Kunnen, Dayton; James F. Morton, Zanesville; Ralph K. Ramsayer, Canton; Robert E. Swank, Chillicothe; Densmore Thomas, Warren; Robert S. VanDervort, Elyria.

**Committee on Medicine and Religion**—George W. Petznick, Cleveland, Chairman; John D. Albertson, Lima; Eugene F. Damstra, Dayton; Francis M. Lenhart, Defiance; Ralph W. Lewis, Portsmouth; J. Kenneth Potter, Cleveland; Charles A. Sebastian, Cincinnati; John R. Seesholtz, Canton; William B. Smith, Zanesville; James T. Stephens, Oberlin; Donald J. Vincent, Columbus; Don G. Warren, West Lafayette.

**Committee on Mental Health**—Wendell A. Butcher, Columbus, Chairman; Homer A. Anderson, Columbus; E. H. Crawford, Cleveland; Max D. Graves, Springfield; Charles W. Harding, Worthington; Warren G. Harding, II, Columbus; Henry L. Hartman, Toledo; J. Robert Hawkins, Cincinnati; William H. Holloway, Akron; Nathan B. Kalb, Lima; Thomas E. Rardin, Columbus; Philip C. Rond, Columbus; Victor M. Victoroff, Cleveland; John A. Whieldon, Columbus.

**Committee on Disaster Medical Care**—Thomas D. Allison, Lima, Chairman; Thomas P. Bowlus, Toledo; Nino M. Camardese, Norwalk; Drew L. Davies, Columbus; John H. Davis, Cleveland; Gregory G. Floridis, Dayton; Robert D. Gillette, Huron; Robert S. Heidt, Cincinnati; N. J. M. Klotz, Wadsworth; Thomas W. Morgan, Gallipolis; Sterling W. Oberauer, Jr., Zanesville; Vol K. Philips, Columbus; Elden C. Weckesser, Cleveland; (Liaison with the American Medical Association) Wendell A. Butcher, Columbus.

**Military Advisory Committee**—Drew L. Davies, Columbus, Chairman; A. A. Brindley, Maumee; Ralph G. Carothers, Cincinnati; Homer D. Cassel, Dayton; Henry A. Crawford, Cleveland; Walter L. Cruise, Zanesville; Charles R. Keller, Mansfield; Ralph W. Lewis, Portsmouth; Edward L. Montgomery, Circleville; Frank T. Moore, Akron; Earl Rosenblum, Steubenville.

**Committee on Occupational Health**—Rex H. Wilson, Akron, Chairman; Drew J. Arnold, Columbus; William W. Davis, Columbus; Winfred M. Dowlin, Canton; Harold M. James, Dayton; H. W. Lawrence, Middletown; Daniel M. Murphy, Marion; Anthony M. Puleo, Cleveland; George W. Wright, Cleveland; H. P. Worstell, Columbus.

**Committee on Poison Control**—John A. Norman, Akron, Chairman; William G. Gilger, Cleveland; Mason S. Jones, Dayton; James H. Bahrenburg, Canton; Edward V. Turner, Columbus; William M. Wallace, Cleveland; Hugh Wellmeier, Piqua; John A. Williams, Cincinnati.

**Committee on Radiation**—Charles M. Barrett, Cincinnati, Chairman; Eldred B. Helsel, Columbus; George F. Jones, Lancaster; Chbey B. Paul, Jr., Columbus; Thomas C. Pomeroy, Columbus; Denis A. Radefeld, Lorain; Eugene L. Saenger, Cincinnati; Robert E. Schulz, Wooster; John P. Storaasli, Cleveland; Robert P. Ulrich, Troy; Robert L. Wall, Columbus; John Robert Yoder, Toledo; James G. Kereikes, Ph.D. (Advisory Member, Special Consultant), Cincinnati.

## STATE ASSOCIATION OFFICERS AND COMMITTEEMEN (Continued)

**Committee on Rural Health**—Robert E. Reiheld, Orrville, Chairman; Chester J. Brian, Eaton; J. Martin Byers, Greenfield; Walter A. Campbell, Coshocton; E. Joel Davis, East Canton; Victor R. Frederick, Urbana; Benjamin W. Gilliotte, Zanesville; Jerry L. Hammon, West Milton; Jasper M. Hedges, Circleville; Luther W. High, Millersburg; E. D. Mattniller, Athens; John R. Polsley, North Lewisburg; Leonard S. Pritchard, Columbiana; Harold C. Smith, Van Wert; Kenneth W. Taylor, Pickerington; Edmond K. Yantes, Wilmington.

**Committee on Scientific and Educational Exhibit**—Charles V. Meckstroth, Columbus, Chairman; Harvey C. Knowles, Jr., Cincinnati; W. Arnold McAlpine, Toledo; Arthur E. Rappoport, Youngstown; Arnold M. Weissler, Columbus; Walter J. Zeiter, Cleveland; Robert E. Zipf, Dayton.

**Committee on School Health**—Charles H. McMullen, Loudonville, Chairman; Walter Felson, Greenfield; Paul D. Hahn, New Philadelphia; Howard H. Hopwood, Cleveland; Dale A. Hudson, Piqua; Howard J. Ickes, Canton; Charles L. Kagay, Dayton; Lawrence L. Maggiano, Warren; Robert C. Markey, Bowling Green; Robert J. Murphy, Columbus; Carey B. Paul, Jr., Columbus; Carl L. Petersilge, Newark; William H. Rower, Ashland; Thomas E. Shaffer, Columbus; Aubrey L. Sparks, Warren; Albert E. Thielen, Cincinnati; Homer B. Thomas, Gallipolis.

**Committee on Traffic Safety**—N. J. Giannestras, Cincinnati, Chairman; Howard W. Bretzell, Steubenville; Drew L. Davies, Columbus; Clark M. Dougherty, New Philadelphia; Wesley L. Furste, Columbus; Thomas W. Morgan, Gallipolis; Lester G. Parker, Sandusky; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus; John F. Tillotson, Lima; Robert C. Waltz, Cleveland; Paul L. Weygandt, Akron; Robert E. Zipf, Dayton.

**Committee on Workmen's Compensation**—H. P. Worstell, Columbus, Chairman; A. L. Berndt, Portsmouth; Thomas H.

Brown, Jr., Toledo; Charles A. Browning, Jr., Bellefontaine; Oscar W. Clarke, Gallipolis; Frederick A. Flory, Columbus; Lawrence T. Hadbavny, Cleveland; Clyde O. Hurst, Portsmouth; Edmund F. Ley, Tiffin; Joseph Lindner, Sr., Cincinnati; John D. Osmond, Jr., Cleveland; James G. Roberts, Akron; George L. Sackett, Sr., Painesville; Joseph H. Shepard, Columbus; William V. Trowbridge, Cleveland; Rex H. Wilson, Akron; Frederick A. Wolf, Cincinnati; James N. Wychgel, Cleveland.

**OSMA Members of the Joint Advisory Committee on Athletic Injuries**—Robert J. Murphy, Columbus; John R. Jones, Toledo; Sol Maggied, West Jefferson; Charles H. McMullen, Loudonville; Carey B. Paul, Jr., Columbus; Thomas E. Shaffer, Columbus; Don A. Kelly, Cleveland; Marvin R. McClellan, Cincinnati; Walter A. Hoyt, Jr., Akron.

**OSMA Members of the Joint Committee on School Bus Driver Examinations**—Carey B. Paul, Jr., Columbus; Thomas N. Quilter, Marion; Stewart M. Rose, Columbus.

### DELEGATES AND ALTERNATES

**Delegates and Alternates to the American Medical Association**—George W. Petznick, Cleveland; H. T. Pease, Wadsworth, alternate; Carl A. Lincke, Carrollton; Robert S. Martin, Zanesville, alternate; Theodore L. Light, Dayton; Kenneth D. Arn, Dayton, alternate; Edmond K. Yantes, Wilmington; Harry K. Hines, Cincinnati, alternate; John H. Budd, Cleveland; P. John Robeck, Cleveland, alternate; Richard L. Melting, Columbus; Robert E. Tschantz, Canton, alternate; Paul F. Orr, Perrysburg; Frederick P. Osgood, Toledo, alternate; Charles A. Sebastian, Cincinnati; J. Robert Hudson, Cincinnati, alternate; Edwin H. Artman, Chillicothe; Philip B. Hardyman, Columbus, alternate. Delegate to take office Jan. 1, 1966, Frederick P. Osgood, Toledo; alternate, Robert N. Smith, Toledo.

## COUNTY SOCIETIES' OFFICERS AND MEETING DATES

### First District

Councillor: Robert E. Howard, Cincinnati 45202  
2600 Union Central Bldg.

**ADAMS**—Gary J. Greenlee, President, Farmers National Bank Bldg., Manchester; Stanley H. Title, Secretary, Seaman.

**BROWN**—John A. Powell, President, 117 Cherry St., Georgetown; Kevin C. McGann, Secretary, 121 N. Main St., Georgetown. 3rd Sunday, monthly.

**BUTLER**—Marvin J. Russell, President, 55 Picadilly Dr., Hamilton; Mr. Charles G. Greig, Executive Secretary, 110 N. 3rd St., Hamilton. 4th Wednesday.

**CLERMONT**—Raymond Lee Davidson, President, 684 Cincinnati-Batavia Pike, Cincinnati 45244; Phillips F. Greene, Secretary, Route 1, Box 509, New Richmond. 3rd Wednesday, monthly.

**CLINTON**—Nathan S. Hale, President, 576 W. Main St., Wilmington; Mary R. Boyd, Secretary, Box 629, Wilmington. 4th Tuesday, 6 p. m., monthly, Clinton Memorial Hospital.

**HAMILTON**—Robert M. Woolford, President, 47 E. Hollister St., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. Council, 2nd Tuesday; Scientific, 3rd Tuesday.

**HIGHLAND**—Thomas C. Sharkey, President, 216 S. High St., Hillsboro; Kenneth L. Upp, Secretary, 528 South St., Greenfield. 1st Wednesday, every other month.

**WARREN**—O. Willard Hoffman, President, 20 E. Fourth St., Franklin; Ray E. Simendinger, 901 Broadway St., Lebanon.

### Second District

Councillor: Theodore L. Light, Dayton 45406  
2670 Salem Ave.

**CHAMPAIGN**—Isador Miller, President, 848 Scioto St., Urbana; Fred R. Denkwalter, Secretary, 848 Scioto St., Urbana. 2nd Wednesday, monthly.

**CLARK**—John F. Riesser, President, First National Bank Building, Springfield; Mrs. Marion L. Wilcoxson, Executive Secretary, Hotel Shawnee, Room 207, Springfield. 3rd Monday, monthly.

**DARKE**—Edward H. Kirsch, President, 261 East Main Street, Gettysburg; Delbert Blickenstaff, Secretary, South West St., Versailles. 3rd Tuesday, monthly.

**GREENE**—R. David Warner, President, Medical Associates Bldg., 140 Riker St., Xenia; Mrs. C. K. Elliott, Executive Secretary, 225 Pleasant St., Xenia. 2nd Thursday, monthly, except July and August.

**MIAMI**—Gerard F. Wolf, President, 145 Sunset Drive, Piqua; Jack P. Steinhilber, Secretary, 145 Sunset Drive, Piqua. 1st Tuesday, monthly.

**MONTGOMERY**—Mason S. Jones, President, 514 Harries Building, Dayton 45402; Mr. Robert F. Freeman, Executive Secretary, 280 Fidelity Medical Building, Dayton 2. 1st Friday, monthly.

**PREBLE**—W. C. Clark, Jr., President, 228 N. Barron St., Eaton; John D. Darrow, Secretary, 1302 N. Aukerman St., Eaton.

**SHELBY**—George J. Schroer, President, 322 Second Ave., Sidney; Alfonsas Kisielius, Secretary, Ohio Bldg., Sidney.

### Third District

Councillor: Frederick T. Merchant, Marion 43305  
1051 Harding Memorial Pky.

**ALLEN**—Vernon A. Noble, President, 1235 West Market Street, Lima; Thomas D. Allison, Secretary, 401 Metropolitan Bank Building, Lima. 3rd Tuesday, monthly, except June, July and August.

**AUGLAIZE**—J. R. Romaker, President, 114 W. Main St., Cridersville; Herbert S. Wolfe, Secretary, Box 238, New Knoxville. 1st Thursday, monthly except July.

**CRAWFORD**—Daniel G. Arnold, President, Medical Arts Building, Bucyrus; Robert E. Solt, Secretary, 140 Hill Street, Bucyrus.

**HANCOCK**—Thomas W. Darnall, President, 1809 South Main Street, Findlay; Herbert L. Queen, Secretary, 827 Woodworth Drive, Findlay. 3rd Tuesday, monthly.

**HARDIN**—Glen B. VanAtta, President, 900 East Franklin Street, Kenton; J. J. Roget, Secretary, Belle Center. 2nd Tuesday, monthly, except June, July and August.

**LOGAN**—Richard A. Firmin, President, Zanesfield; Gerald Munn, Secretary, 120 E. Sandusky Ave., Bellefontaine. 1st Friday, monthly.

**MARION**—James A. McGlew, President, 399 E. Church St., Marion; Lester E. Wall, Secretary, 317 S. Main St., Marion. 1st Tuesday, monthly.

**MERCER**—Robert W. Albers, President, 407 S. Oak St., Coldwater; C. E. Pennington, 407 S. Oak St., Coldwater. 3rd Thursday.

**SENECA**—James A. Murray, President, 502 Van Buren St., Fostoria; Lowell K. Good, Secretary, 133 W. North St., Fostoria.

**VAN WERT**—Harold C. Smith, President, Medical Arts Bldg., Van Wert; Donald E. Hughes, Secretary, Van Wert County Hospital, Van Wert. 4th Tuesday, monthly.

**WYANDOT**—Franklin M. Smith, President, E. Saffie Ave., Box 68, Sycamore; Robert E. Goyné, Secretary, 482 N. 7th St., Upper Sandusky. 2nd Tuesday, monthly.

### Fourth District

Councillor: Robert N. Smith, Toledo 43606  
3939 Monroe St.

**DEFIANCE**—John W. Cullen, President, Box 218, Defiance; William S. Busted, Secretary, Box 218, Defiance. 1st Saturday, monthly.

**FULTON**—Benjamin H. Reed, Jr., President, 101 Adrian St., Delta; Richard L. Davis, Secretary, 137 S. Fulton St., Wauseon. 2nd Tuesday, March, June, September and December.

**HENRY**—Thomas F. Moriarty, President, 515 Avon Place, Napoleon; Gamble S. Hall, Secretary, 834 Strong St., Napoleon. 1st Tuesday, monthly.

**LUCAS**—R. Philip Whitehead, President, 424 W. Woodruff Ave., Toledo 43602; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 10. 3rd Tuesday.

**OTTAWA**—Robert Reeves, Route 1, Oak Harbor; Kenneth L. Akins, Secretary, 208 W. Third St., Port Clinton. 2nd Thursday, monthly.



**PAULDING**—Don K. Snyder, President, Payne; Roy R. Miller, Secretary, 220 W. Perry St., Paulding. Meetings as called.

**PUTNAM**—John R. Brown, President, 135 South Hickory Street, Ottawa; Oliver N. Luginbill, Secretary, Pandora. 1st Tuesday monthly.

**SANDUSKY**—J. L. Zimmerman, President, Memorial Hospital, Fremont; Patsy J. Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday, monthly.

**WILLIAMS**—Donald F. Cameron, President, Central Drive, Bryan; John E. Moats, Secretary, Central Drive, Bryan.

**WOOD**—Louis P. Baldoni, President, 195 E. Broadway, Perrysburg; Paul R. Overhulse, Secretary, 115 Clay St., Bowling Green. 3rd Thursday, monthly.

## Fifth District

Councilor: P. John Robechek, Cleveland 44106  
10525 Carnegie Ave.

**ASHTABULA**—Harmon O. Tidd, President, 362 Rogers Place, Ashtabula; William F. Doran, Secretary, 241 Mill St., Conneaut. 2nd Tuesday, monthly.

**CUYAHOGA**—William F. Boukalik, President, 20030 Scottsdale Blvd., Cleveland; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Avenue, Cleveland 6.

**GEAUGA**—Simon Ohanessian, President, Medical Arts Bldg., 13221 Ravenna Road, Chardon; Chanoir Adrian, Secretary, Medical Arts Bldg., 13221 Ravenna Road, Chardon. 2nd Friday evening, monthly.

**LAKE**—Wesley J. Pignolet, President, 36001 Euclid Avenue, Willoughby; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadie Avenue, Mentor. 4th Wednesday evening of January, March, May, September and November.

## Sixth District

Councilor: Edwin R. Westbrook, Warren 44481  
438 North Park Ave.

**COLUMBIANA**—Peter Cibula, President, 356 E. Lincoln Way, Lisbon; Ernst P. Schaefer, Secretary, 412 N. Lincoln Ave., Salem. 3rd Tuesday, monthly.

**MAHONING**—John J. McDonough, President, 1005 Belmont Ave., Youngstown 44504; Mr. Howard C. Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 3rd Tuesday, monthly, except July and August.

**PORTAGE**—George R. Sprogis, President, Hiram College, Hiram; William Brinker, Secretary, 141 East Main Street, Kent. 3rd Tuesday at 9 P.M., monthly.

**STARKE**—Harold J. Bowman, President, 515-3rd St. N.W., Canton 44703; Mr. J. H. Austin, Executive Secretary, 405 Fourth St., N.W., Canton 44702. 2nd Thursday, monthly.

**SUMMIT**—Wendell T. Bucher, President, 315 Ohio Building, Akron; Mr. S. H. Mountcastle, Executive Secretary, 437 Second National Building, Akron. 1st Tuesday, monthly except July and August.

**TRUMBULL**—John Schlecht, President, Trumbull Memorial Hospital, Warren; Mrs. Kay Ticknor, Executive Secretary, 318 N. Park Ave., Warren. 3rd Wednesday, monthly.

## Seventh District

Councilor: Benj. C. Diefenbach, Martins Ferry 43935  
30 S. 4th St.

**BELMONT**—Robert N. Lewis, President, 100 W. Main Street, St. Clairsville; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry. 3rd Thursday, monthly.

**CARROLL**—Jack L. Maffett, President, 264 South Lisbon Street, Carrollton; Thomas J. Atchison, Secretary, 292 East Main Street, Carrollton. 1st Thursday, monthly.

**COSHOCOTON**—Don G. Warren, President, 600 E. Main St., West Lafayette; H. W. Lear, Secretary, 133 S. 4th St., Coshocton. 2nd Tuesday, monthly.

**HARRISON**—Elias Freeman, President, 259 Jamison Ave., Cadiz; Richard W. Weiser, Secretary, Main and Cadiz Sts., Jewett. Quarterly.

**JEFFERSON**—Paul W. Ruksha, President, 647 Commercial St., Mingo Junction; Irving Dreyer, Secretary, Union Bank Bldg., Toronto. 4th Tuesday, monthly, except December, January and February.

**MONROE**—Byron Gillespie, Secretary, S. Main St., Woodsfield.

**TUSCARAWAS**—J. H. Winston, President, 658 Boulevard, Dover; G. W. Johnston, Secretary, 658 Boulevard, Dover. 2nd Thursday, monthly.

## Eighth District

Councilor: Robert C. Beardsley, Zanesville 43705  
2236 Maple Ave.

**ATHENS**—Robert E. Main, President, 400 East State Street, Athens; Lester A. Hamilton, Secretary, 400 East State Street, Athens. 2nd Tuesday at noon, monthly.

**FAIRFIELD**—Victor A. Simiele, President, Equitable Building, Lancaster; Stephen R. Hodsdon, Secretary, 1423 West Market Street, Baltimore. 2nd Tuesday, monthly.

**GUERNSEY**—M. Hnatuk, President, 24 Mill St., Seneca; Dayle O. Snyder, Secretary, 840 Wheeling Ave., Cambridge.

**LICKING**—Gerald A. Erhard, President, 36 West Locust Street, Newark; James A. Quinn, Jr., Secretary, 212 Everett Avenue, Newark. 4th Tuesday evening, monthly.

**MORGAN**—A. H. Whitacre, President, Chesterhill; Henry Bachman, Secretary, Box 199, Malta.

**MUSKINGUM**—Robert B. Morrison, President, 705 Forest Avenue, Zanesville; Myron H. Powelson, Secretary, 2825 Maple Avenue, Zanesville. 1st Tuesday, monthly.

**NOBLE**—F. M. Cox, President, Caldwell; E. G. Ditch, Secretary, Caldwell. 2nd Tuesday, monthly.

**PERRY**—O. D. Ball, President, 203 N. Main St., New Lexington; Michael P. Clouse, Secretary, W. Main St., Somerset.

**WASHINGTON**—Donald Fleming, President, Vincent; Archbold M. Jones, Jr., Secretary, 326 Third St., Marietta.

## Ninth District

Councilor: George N. Spears, Ironton 45638  
2213 S. 9th St.

**GALLIA**—Leonard Harris, President, Holzer Clinic, Gallipolis; James A. Kemp, Secretary, Holzer-Clinic, Gallipolis. Quarterly meetings at called times.

**HOCKING**—Jan S. Matthews, President, 9 E. Second St., Logan; Howard M. Boocks, Secretary, Route 3, Logan. 1st Tuesday, monthly.

**JACKSON**—A. R. Hambrick, President, Wellston; John C. MacLennan, Secretary, Oak Hill. Meeting date varies.

**LAWRENCE**—Vallee W. Blagg, President, 1805 S. 4th St., Ironton; George Newton Spears, Secretary, 2213 S. 9th St., Ironton. Quarterly meetings.

**MEIGS**—Selim J. Blazewicz, President, Lasley St., Pomeroy; Roger P. Daniels, Secretary, 110 Ebenezer St., Pomeroy. Approximately once monthly.

**PIKE**—A. M. Shrader, President, E. Water St., Waverly; K. A. Wilkinson, Secretary, 330 E. North St., Waverly. 1st Tuesday, monthly.

**SCIOTO**—William E. Daehler, President, 1004 24th Street, Portsmouth; Spencer K. Miller, Secretary, 5701 Gallia Street, Scioto. 2nd Monday in February, April and October. Dates for meetings in June or July and December to be determined annually.

**VINTON**—Richard E. Bullock, President, 203 S. Market St., McArthur; David Gaul, Secretary, 107 W. Main St., McArthur. Called meetings.

## Tenth District

Councilor: Richard L. Fulton, Columbus 43212  
1211 Dublin Rd.

**DELAWARE**—Robert S. Caulkins, President, 265 West Lincoln Avenue, Delaware; Tennyson Williams, Secretary, Box 265, Delaware. 3rd Tuesday at 6:30 P.M., monthly.

**FAYETTE**—Thomas J. Hancock, President, 220 E. Market St., Washington C. H.; Marvin H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 2nd Friday, monthly.

**FRANKLIN**—John R. Huston, President, 350 East Broad Street, Columbus; Mr. William Webb, Jr., Executive Secretary, 79 East State Street, Columbus. 3rd Monday, monthly.

**KNOX**—Richard L. Smythe, President, Medical Arts Building, Mt. Vernon; Robert E. Sooy, Secretary, 426 Wooster Road, Mt. Vernon.

**MADISON**—Francis E. Rosnagle, President, 98 Flax Dr., London; Jack Grant, Secretary, Madison County Hospital, London. Quarterly 2nd Wednesday of month.

**MORROW**—Joseph F. Ingmire, President, 28 West High Street, Mt. Gilead; Frank Sweeney, Secretary, 46 South Main Street, Mt. Gilead. 1st Tuesday, monthly.

**PICKAWAY**—Ray Carroll, President, 121 N. Pickaway St., Circleville; Carlos Alvarez, Secretary, 147 Pinckney Drive. 1st Friday, monthly.

**ROSS**—Paul F. MacCarter, President, 60 Central Center, Chillicothe; Richard L. Counts, Secretary, 56 E. Second St., Chillicothe.

**UNION**—Malcolm MacIvor, President, 110 N. Court St., Marysville; May B. Zaugg, Secretary, 130 N. Maple St., Marysville. 1st Tuesday of February, April, October and December.

## Eleventh District

Councilor: William R. Schultz, Wooster 44691  
1749 Cleveland Road

**ASHLAND**—Paul E. Kellogg, President, 4-6 Farmers Bank Building, Ashland; Vera Clem Chalfant, Secretary, 309 Arthur Street, Ashland. 1st Thursday, monthly.

**ERIE**—Fred Lavender, President, 1218 Cleveland Road, Sandusky; Robert D. Gillette, Secretary, P. O. Box 127, Huron. Alternate 3rd Tuesday and Thursday, monthly.

**HOLMES**—Owen F. Patterson, President, 8 N. Clay St., Millersburg; William A. Powell, Secretary, W. Adams St., Millersburg. 2nd Wednesday, monthly.

**HURON**—William B. Holman, President, 257 Benedict Ave., Norwalk; Earl R. McLoney, Secretary, 257 Benedict Ave., Norwalk. 2nd Wednesday evening of February, April, June, August, October and December.

**LORAIN**—John W. Wherry, President, 632 Cleveland St., Elyria; John Gladys Davidson, Executive Secretary, 428 West Ave., Elyria. 2nd Tuesday.

**MEDINA**—Richard C. Glosch, President, 402 Highland Drive, Lodi; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina. 3rd Thursday, monthly.

**RICHLAND**—Stanley L. Brody, President, 327 Park Ave W., Mansfield; Wendell M. Bell, Secretary, 480 Glessner Ave., Mansfield. 3rd Thursday, monthly.

**WAYNE**—John M. Robinson, President, 1478 Cleveland Road, Wooster; Richard J. Watkins, Secretary, 1736 Beall Ave., Wooster. 2nd Wednesday.

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JOHN H. SMITH, M.D.

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## Correction

In the October issue of *The Journal*, page 924, the field of practice of Dr. John S. Collis was incorrectly given. Dr. Collis is certified by the American Board of Neurological Surgery, and practices in the specialty of that board. He was a member of the Cleveland Clinic Foundation team which sponsored the Silver Award winning exhibit at the OSMA 1965 Annual Meeting, entitled "Lumbar Discography; A Twelve Year Experience."

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